DEPARTMENT OF PUBLIC HEALTH
AND HUMAN SERVICES

CHAPTER 86

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Subchapter 1

Physician Services

37.86.101 PHYSICIAN SERVICES, DEFINITIONS

(1) "Physician services" means those services provided by individuals licensed under the State Medical Practice Act to practice medicine or osteopathy which, as defined by state law, are within the scope of their practice.

(2) "Usual and customary" means those charges that the billing physician would charge for a particular service in a majority of cases, including medicaid and non-medicaid patients.

(3) The department hereby adopts and incorporates by reference the definitions found in the introduction to Physicians Current Procedural Terminology, fourth edition (CPT4), published by the American medical association of Chicago, Illinois. These materials set forth meanings of terms commonly used by the Montana medicaid program in implementation of the program's physician fee schedule. A copy of the definitions herein incorporated may be obtained through the Department of Public Health and Human Services, Health Policy and Services Division, Medicaid Services Bureau, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-113 and 53-6-141, MCA; NEW, 1980 MAR p. 1747, Eff. 6/27/80; AMD, 1988 MAR p. 1255, Eff. 7/1/88; AMD, 1991 MAR p. 1030, Eff. 7/1/91; AMD, 1994 MAR p. 313, Eff. 2/11/94; TRANS, from SRS, 2000 MAR p. 481.)

Rules 02 and 03 reserved

37.86.104 PHYSICIAN SERVICES, REQUIREMENTS (1) These requirements are in addition to those rule provisions generally applicable to medicaid providers.

(2) The department or its designated review organization may conduct utilization and peer review of physician services.

(3) Physician services for conditions or ailments that are generally considered cosmetic in nature are not a benefit of the medicaid program except in such cases where it can be demonstrated that the physical and psycho-social well being of the recipient is severely affected in a detrimental manner by the condition or ailment. Such services must be prior authorized by the medicaid services bureau, based on recommendations of the designated peer review organization.

(a) A request for prior authorization must include all relevant information to justify the need for the service. This information includes statements from a physician qualified in the area of concern and a potential provider.

(b) The information must clearly document the necessity for the service and include assurances that the plan will be followed to completion.

(4) Coverage of physician services for sterilization is limited as follows:

(a) The recipient to be sterilized must not be declared mentally incompetent by a federal, state, or local court of law.

(b) The recipient to be sterilized must be 21 years of age or older at the time informed consent to sterilization is obtained from the recipient.

(c) The recipient to be sterilized must not be institutionalized in a corrective, penal, mental, or rehabilitative facility.

(5) Physician services for sterilization must meet the following requirements in order to receive medicaid reimbursement:

(a) The recipient to be sterilized must give informed consent, in accordance with the medicaid approved informed consent to sterilization form, not less than 30 days nor more than 180 days prior to sterilization except in the case of premature delivery or emergency abdominal surgery. For these exceptions, at least 72 hours must pass between informed consent and the sterilization procedure. In cases of premature delivery, informed consent must be given at least 30 days before the expected delivery date.

(b) The recipient to be sterilized, the person who obtained the consent, and the interpreter (if required) must sign the informed consent form at least 30 days but not more than 180 days prior to the sterilization. The physician performing the sterilization must sign and date the informed consent form after the sterilization has been performed.

(c) A copy of the informed consent to sterilization form must be attached to the medicaid claim when billing for sterilization procedures.

(6) Coverage of physician services for hysterectomies is limited as follows:

(a) The surgery must not be solely for the purpose of rendering the recipient incapable of reproducing; and

(b) The surgery must be medically necessary to treat injury or pathology.

(7) Physician services for hysterectomies must meet the following requirements in order to receive medicaid reimbursement:

(a) The physician must inform the recipient that the hysterectomy will render her permanently incapable of reproducing;

(b) A completed copy of the approved acknowledgment of receipt of hysterectomy information form must be attached to the medicaid claim when billing for hysterectomy services;

(c) In a case where the recipient is sterile before the hysterectomy or there is a life-threatening emergency that precludes the recipient from giving prior acknowledgment of receipt of hysterectomy information the requirements in (7)(a) and (7)(b) do not apply. Instead the physician who performed the hysterectomy either:

(i) must certify in writing that the recipient was sterile before the hysterectomy and state the cause of sterility; or

(ii) must certify in writing that the hysterectomy was performed during a life-threatening emergency situation that precluded the recipient from giving prior acknowledgment of receipt of hysterectomy information and gives a description of the nature of the emergency.

(8) Coverage of physician services for abortions is limited as follows:

(a) the life of the mother will be endangered if the fetus is carried to term; or

(b) the pregnancy is the result of an act of rape or incest.

(9) Physician services for abortions in a case of endangerment of the mother's life must meet the following requirements in order to receive medicaid reimbursement:

(a) The physician must find, and certify in writing, that in the physician's professional judgement, the life of the mother will be endangered if the fetus is carried to term. The certification must contain the name and address of the patient and must be on or attached to the medicaid claim.

(10) Physician services for abortions in cases of pregnancy resulting from an act of rape or incest must meet the following requirements in order to receive medicaid reimbursement:

(a) the recipient certifies in writing that the pregnancy resulted from an act of rape or incest; and

(b) the physician certifies in writing either that:

(i) the recipient has stated to the physician that she reported the rape or incest to a law enforcement or protective services agency having jurisdiction over the matter, or if the recipient is a child enrolled in a school, to a school counselor; or

(ii) in the physician's professional opinion, the recipient was and is unable for physical or psychological reasons to report the act of rape or incest.

(11) Physician services for routine podiatric care and orthotics must be in accord with the definitions of ARM 37.86.501 and meet the requirements of ARM 37.86.505. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-141, MCA; NEW, 1980 MAR p. 1747, Eff. 6/27/80; AMD, 1980 MAR p. 2664, Eff. 9/26/80; AMD, 1981 MAR p. 1061, Eff. 9/18/81; AMD, 1983 MAR p. 757, Eff. 7/1/83; AMD, 1988 MAR p. 1255, Eff. 7/1/88; AMD, 1991 MAR p. 824, Eff. 5/31/91; AMD, 1991 MAR p. 1030, Eff. 7/1/91; AMD, 1994 MAR p. 2975, Eff. 11/11/94; AMD, 1995 MAR p. 1580, Eff. 8/11/95; TRANS, from SRS, 2000 MAR p. 481.)

37.86.105 PHYSICIAN SERVICES, REIMBURSEMENT/GENERAL REQUIREMENTS AND MODIFIERS (1) Providers must bill for services using the procedure codes and modifiers set forth, and according to the definitions contained, in the health care financing administration's common procedure coding system (HCPCS). Information regarding billing codes, modifiers and HCPCS is available upon request from the health policy and services division at the address stated in ARM 37.86.101(3).

(2) Reimbursement for physician services, except as otherwise provided in this rule, is the lower of:

(a) the provider's usual and customary charges (billed charges);

(b) the department's fee schedule maintained in accordance with the methodologies described in ARM 37.85.212; or

(3) Reimbursement for services of a psychiatrist, except as otherwise provided in this rule, is the lower of:

(a) the provider's usual and customary charges (billed charges); or

(b) to address problems of access to mental health services, subject to funding, up to 125% of the reimbursement for physicians provided in accordance with the methodologies described in ARM 37.85.212.

(4) Reimbursement to physicians for physician-administered drugs which are billed under HCPCS "J" and "Q" codes is either according to a fee schedule established by the department and updated at least annually based upon the Montana estimated acquisition cost or maximum allowable cost, as defined in ARM 37.86.1101 or the provider's usual and customary charge, whichever is lower. No dispensing fee is paid to physicians.

(a) The maximum allowable cost limitation shall not apply in those cases where the physician certifies in their own handwriting that in their medical judgment a specific brand name drug is medically necessary for a particular patient. Acceptable certification statements are "brand necessary" or "brand required". A check-off box on a form or a rubber stamp is not acceptable. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-113 and 53-6-141, MCA; NEW, 1980 MAR p. 1808, Eff. 6/27/80; AMD, 1981 MAR p. 559, Eff. 6/12/81; AMD, 1981 MAR p. 1976, Eff. 1/1/82; AMD, 1982 MAR p. 1289, Eff. 7/1/82; AMD, 1987 MAR p. 1496, Eff. 8/28/87; AMD, 1988 MAR p. 1255, Eff. 7/1/88; AMD, 1989 MAR p. 881, Eff. 6/30/89; AMD, 1989 MAR p. 880, Eff. 7/1/89; AMD, 1990 MAR p. 1179, Eff. 6/15/90; AMD, 1990 MAR p. 1608, Eff. 8/17/90; AMD, 1990 MAR p. 2305, Eff. 12/28/90; AMD, 1991 MAR p. 824, Eff. 5/31/91; AMD, 1991 MAR p. 1030, Eff. 7/1/91; AMD, 1997 MAR p. 1269, Eff. 7/22/97; AMD, 1998 MAR p. 676, Eff. 3/13/98; TRANS, from SRS, 2000 MAR p. 481; AMD, 2001 MAR p. 27, Eff. 1/12/01; AMD, 2001 MAR p. 1476, Eff. 8/10/01; AMD, 2001 MAR p. 2156, Eff. 10/26/01.)

Rules 06 and 07 reserved

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37.86.108 MENTAL HEALTH SERVICES PLAN, APPLICATION FORMS, INCOME VERIFICATION (1) Application forms and information regarding eligibility for the plan are available at all local county human services departments.

(2) The applicant must submit with the application form a completed and signed income statement and the necessary documentation to verify the income reported.

(3) For purposes of (2), necessary income verification may include one or more of the following or other appropriate and persuasive documentation:

(a) pay stubs or other pay statements;

(b) employee's W-2 forms;

(c) state or federal income tax returns and associated forms and schedules;

(d) union records;

(e) check copies;

(f) self-employment bookkeeping records;

(g) sales and expenditure records;

(h) employer's wage or payroll records;

(i) award notices or award letters;

(j) correspondence specifying a benefit;

(k) records of any government payer;

(l) court records or correspondence from attorneys;

(m) financial institution records;

(n) insurance company correspondence or records; or

(o) college or university financial aid correspondence or records. (History: Sec. 41-3-1103, 53-2-201, 53-6-113, 53-6-131, 53-6-701 and 53-6-706, MCA; IMP, Sec. 41-3-1103, 53-1-601, 53-1-602, 53-2-201, 53-6-101, 53-6-113, 53-6-116, 53-6-117, 53-6-131, 53-6-701, 53-6-705, 53-6-706, 53-21-139 and 53-21-202, MCA; NEW, 2001 MAR p. 27, Eff. 1/12/01.)

Rule 09 reserved

37.86.110 MENTAL HEALTH SERVICES PLAN, ELIGIBILITY REDETERMINATIONS, MEMBERS REQUIRED TO NOTIFY DEPARTMENT OF CHANGES, REPAYMENT OF BENEFITS (1) Eligibility determinations under ARM 37.89.106 are effective until the earlier of:

(a) 1 year; or

(b) the effective date of any redetermination.

(2) The department may redetermine eligibility at any time.

(a) Eligibility must be redetermined within 1 year after the most recent determination or sooner based upon changes in income, family composition or the federal poverty level. Members may be required to submit completed forms and verification by a specified date for purposes of eligibility redetermination.

(b) Members must give notice of any change in total family income or family composition within 30 days of the change. Failure to give notice will be grounds for termination of eligibility until such time as complete and accurate income and family composition information is provided.

(c) Termination of eligibility, based upon a change in the federal poverty level, income or family composition, may not be effective earlier than 10 days after mailing of written notice of termination to the member.

(d) An individual is liable to the department and the department may collect from the individual the amount of actual payments by the department or its agents to providers for any services furnished to the individual because of misrepresentation of income or a failure to give the required notice of changes in income or family composition. (History: Sec. 41-3-1103, 53-2-201, 53-6-113, 53-6-131, 53-6-701 and 53-6-706, MCA; IMP, Sec. 41-3-1103, 53-1-601, 53-1-602, 53-2-201, 53-6-101, 53-6-113, 53-6-116, 53-6-117, 53-6-131, 53-6-701, 53-6-705, 53-6-706, 53-21-139 and 53-21-202, MCA; NEW, 2001 MAR p. 27, Eff. 1/12/01.)

Rule 11 reserved

37.86.112 MENTAL HEALTH SERVICES PLAN, EMERGENCY MENTAL HEALTH SERVICES, LIABILITY FOR FAILURE TO COMPLETE APPLICATION

(1) A nonmember receiving covered emergency mental health services, which do not include hospital emergency room or other hospital services, is eligible on an emergency basis for the plan and may receive covered medically necessary services for a covered diagnosis unless the provider determines that the individual has the means, financially or otherwise, by which to make payment. If the individual is subsequently determined ineligible for the plan or fails to complete an application for plan eligibility within 60 days following completion of emergency treatment, the individual is liable for and may be billed by the provider at its usual and customary (billed charges) private pay charges or by the department for the amount of payments actually made by the department or its agents to the provider for the services provided. (History: Sec. 41-3-1103, 53-2-201, 53-6-113, 53-6-131, 53-6-701 and 53-6-706, MCA; IMP, Sec. 41-3-1103, 53-1-601, 53-1-602, 53-2-201, 53-6-101, 53-6-113, 53-6-116, 53-6-117, 53-6-131, 53-6-701, 53-6-705, 53-6-706, 53-21-139 and 53-21-202, MCA; NEW, 2001 MAR p. 27, Eff. 1/12/01.)

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Subchapter 2

Mid-level Practitioner Services

37.86.201 MID-LEVEL PRACTITIONER SERVICES, REQUIREMENTS

(1) ARM 37.86.202 and 37.86.205 provide the requirements for medicaid coverage of mid-level practitioner services. The requirements in these rules are in addition to those contained in ARM 37.85.401 through 37.85.414. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 1987 MAR p. 1688, Eff. 10/1/87; AMD, 1994 MAR p. 313, Eff. 2/11/94; TRANS, from SRS, 2000 MAR p. 481.)

37.86.202 MID-LEVEL PRACTITIONER SERVICES, DEFINITIONS

For the purpose of these rules, the following definitions will apply:

(1) "Advanced practice registered nurse" means a registered professional nurse licensed as provided in Title 37, chapter 8, MCA and ARM Title 8, chapter 32, subchapter 3 and includes nurse practitioner, nurse anesthetist, and nurse midwife and clinical nurse specialist.

(2) "Clinical nurse specialist" means a person who is licensed in accord with 37-8-405 through 37-8-407, MCA and ARM 8.32.304 through 8.32.307.

(3) "Delivery services" means services necessary to protect the health and safety of the woman and fetus from the onset of labor through delivery.

(4) "Independent employment status" means that a separate federal tax identification number is obtained for the mid-level practitioner and the billed services are not provided in the course of the mid-level practitioner's employment by or contract with a physician, hospital or ambulatory surgical center.

(5) "Mid-level practitioner" means the following professionals:

(a) advanced practice registered nurse; and

(b) physician assistant.

(6) "Mid-level practitioner services" means those services provided by mid-level practitioners in accord with the laws and rules defining and governing through licensing and certification the practices of advanced practice registered nurses and physician assistants.

(7) "Nurse anesthetist" means a person who is licensed in accord with 37-8-405 through 37-8-407, MCA and ARM 8.32.303 through 8.32.306.

(8) "Nurse midwife" means a person who is licensed in accord with 37-8-405 through 37-8-407, 37-8-409, MCA and ARM 8.32.302, 8.32.304 through 8.32.306.

(9) "Nurse practitioner" means a person who is licensed in accord with 37-8-405 through 37-8-407, MCA and ARM 8.32.301, 8.32.304 through 8.32.306.

(10) "Physician assistant" means a person who is licensed as provided in Title 37, chapter 20, MCA and ARM Title 8, chapter 28, subchapter 15.

(11) "Postpartum services" means services rendered to a woman during the 60-day period following the delivery for any health conditions or complications that are pregnancy-related.

(12) "Pregnancy-related services" means services for the treatment of conditions or complications that exist or are exacerbated because of pregnancy.

(13) "Prenatal services" means services directed at protecting and insuring the health of the woman and the fetus during pregnancy. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 1987 MAR p. 1688, Eff. 10/1/87; AMD, 1991 MAR p. 1044, Eff. 6/28/91; AMD, 1994 MAR p. 313, Eff. 2/11/94; AMD, 1995 MAR p. 1580, Eff. 8/11/95; AMD, 1997 MAR p. 548, Eff. 3/25/97; TRANS, from SRS, 2000 MAR p. 481.)

Rules 03 and 04 reserved

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37.86.205 MID-LEVEL PRACTITIONER SERVICES, REQUIREMENTS AND REIMBURSEMENT (1) These requirements are in addition to those rule provisions generally applicable to medicaid providers.

(2) Medicaid coverage of mid-level practitioner services is available according to the requirements and procedures specified for physicians under ARM 37.86.101, 37.86.104 and 37.86.105.

(3) Mid-level practitioner services must be medically necessary as defined in ARM 37.82.102 and 37.85.410.

(4) Coverage of mid-level practitioner services is limited to the provision of services by the following providers:

(a) mid-level practitioners who are considered to have an independent employment status.

(b) hospitals employing or contracting with certified registered nurse anesthetists if:

(i) the secretary of health and human services has not granted the hospital authorization for continuation of cost pass-through under section 9320 of the Omnibus Budget Reconciliation Act of 1986, as amended by section 608(c) of the Family Support Act of 1988 (public law 100-485);

(ii) the hospital obtains from the department or its fiscal agent a provider number for certified registered nurse anesthetist services; and

(iii) the hospital bills for services on form HCFA-1500.

(c) physicians, ambulatory surgical centers, diagnostic centers or public health departments, employing or contracting with mid-level practitioners if:

(i) the physician or the provider entity obtains from the department or its fiscal agent a provider number for the mid-level practitioner; and

(ii) the physician or the provider entity bills for services on form HCFA-1500.

(5) Reimbursement for services, except as otherwise provided in this rule, is the lower of:

(a) usual and customary charges; or

(b) 90% of the reimbursement for physicians provided in accordance with the methodologies described in ARM 37.85.212 and 37.86.105.

(6) Reimbursement for immunizations, family planning services, administration of injectables, radiology, laboratory and pathology, cardiography and echocardiography services and for early and periodic screening, diagnostic and treatment services is the lower of:

(a) usual and customary charges; or

(b) 100% of the reimbursement for physicians provided in accordance with the methodologies described in 37.85.212 and 37.86.105.

(7) A mid-level practitioner shall submit all claims for services personally provided by the mid-level practitioner, using the mid-level practitioner's own medicaid provider number and any appropriate modifiers, unless another provider is authorized to bill for services provided by the mid-level practitioner by administrative rule or state law.

(8) Reimbursement for drugs which are billed under HCPCS "J" and "Q" codes is the lower of:

(a) the usual and customary charge; or

(b) 100% of reimbursement for physicians in accordance with ARM 37.86.105.

(9) The following services are not covered by medicaid as mid-level practitioner services:

(a) educational visits and educational materials (including group settings);

(b) mileage and travel expenses;

(c) no show or cancelled appointments;

(d) preparation of special medical or insurance reports;

(e) consultations with other mid-level practitioners;

(f) delivery services not provided in a licensed health care facility unless provided in an emergency situation; and

(g) drug dispensing fees. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 1987 MAR p. 1688, Eff. 10/1/87; AMD, 1988 MAR p. 1255, Eff. 7/1/88; AMD, 1989 MAR p. 1848, Eff. 11/10/89; AMD, 1990 MAR p. 540, Eff. 3/16/90; AMD, 1990 MAR p. 2299, Eff. 12/28/90; AMD, 1990 MAR p. 2305, Eff. 12/28/90; AMD, 1991 MAR p. 1044, Eff. 6/28/91; AMD, 1994 MAR p. 313, Eff. 2/11/94; AMD, 1995 MAR p. 1580, Eff. 8/11/95; AMD, 1997 MAR p. 1269, Eff. 7/22/97; AMD, 1998 MAR p. 676, Eff. 3/13/98; TRANS, from SRS, 2000 MAR p. 481; AMD, 2002 MAR p. 1775, Eff. 6/28/02.)

Subchapters 3 and 4 reserved

Subchapter 5

Podiatry Services

37.86.501 PODIATRY SERVICES, DEFINITIONS (1) "Orthotic" means a mechanical device to assist in restoring normal function of the foot, applied to the foot or used with the shoe either as an insert for the shoe or as an attachment to the exterior of the shoe.

(2) "Podiatry services" means those services provided by individuals licensed under state law to practice podiatry which are within the scope of their practice.

(3) "Routine podiatric care" means the cutting or removing of corns and calluses, the trimming of nails or the application of skin creams and other hygienic, preventive maintenance care and debridement of nails. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-141, MCA; NEW, 1980 MAR p. 2664, Eff. 9/26/80; AMD, 1995 MAR p. 1580, Eff. 8/11/95; TRANS, from SRS, 2000 MAR p. 481.)

Rules 02 through 04 reserved

37.86.505 PODIATRY SERVICES, REQUIREMENTS (1) These requirements are in addition to those rule provisions generally applicable to medicaid providers.

(2) The department or its designated review organization may conduct utilization and peer review of podiatry services. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-141, MCA; NEW, 1980 MAR p. 2664, Eff. 9/26/80; AMD, 1991 MAR p. 1030, Eff. 7/1/91; AMD, 1995 MAR p. 1580, Eff. 8/11/95; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 866, Eff. 3/31/00.)

37.86.506 PODIATRY SERVICES, REIMBURSEMENT

(1) Reimbursement for podiatry services is in accordance with the methodologies described in ARM 37.85.212 and 37.86.105. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-111, 53-6-131 and 53-6-141, MCA; NEW, 1980 MAR p. 2664, Eff. 9/26/80; AMD, 1981 MAR p. 559, Eff. 6/12/81; AMD, 1982 MAR p. 1289, Eff. 7/1/82; AMD, 1989 MAR p. 859, Eff. 6/30/89; AMD, 1990 MAR p. 1479, Eff. 7/27/90; AMD, 1991 MAR p. 1030, Eff. 7/1/91; AMD, 1995 MAR p. 1580, Eff. 8/11/95; AMD, 1997 MAR p. 1269, Eff. 7/22/97; AMD, 1998 MAR p. 676, Eff. 3/13/98; TRANS, from SRS, 2000 MAR p. 481.)

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Subchapter 6

Therapy Services

37.86.601 THERAPY SERVICES, DEFINITIONS In ARM 37.86.601, 37.86.605, 37.86.606, 37.86.610, 46.12.526 and 46.12.529, the following definitions apply:

(1) "Assistant/aide" means an assistant, aide or other person authorized under and practicing in accordance with the applicable provisions of Title 37, MCA, who subject to supervision required by law, assists in the provision of a therapy service.

(2) "Condition" means an illness, injury, disorder or disability.

(3) "Licensed therapist" means a physical therapist, speech-language pathologist or occupational therapist licensed under the applicable provisions of Title 37, MCA to practice the particular category of therapy services provided, but does not include an assistant, aide or other person whose authority to perform services is restricted to working under the supervision of another.

(4) "Maintenance therapy" means repetitive therapy services that are required to maintain functions, that are performed without reasonable expectation of significant progress and that do not involve complex and sophisticated therapy services requiring the judgment or skill of a licensed therapist.

(5) "Mid-level practitioner" means an advanced practice registered nurse or a physician assistant as defined in ARM 37.86.202.

(6) "Occupational therapy services" means occupational therapy services as defined in 37-24-103, MCA. For purposes of ARM 37.86.601, 37.86.605, 37.86.606, 37.86.610, 46.12.526 and 46.12.529, occupational therapy services do not include services provided by a hospital or home health agency.

(7) "Physical therapy services" means physical therapy services as defined in 37-11-101, MCA. For purposes of ARM 37.86.601, 37.86.605, 37.86.606, 37.86.610, 46.12.526 and through 46.12.529, physical therapy services do not include services provided by a hospital or home health agency.

(8) "Restorative therapy" means therapy services that are performed with a reasonable expectation that the recipient's function will improve significantly in a reasonable and predictable period of time, based upon an assessment of the recipient's restoration potential made by a physician or mid-level practitioner in consultation, with the licensed therapist. Therapy services are not restorative therapy if the recipient's expected restoration potential would be insignificant in relation to the extent and duration of services required. Therapy services are no longer restorative therapy if at any time after commencement of treatment it is determined that the reasonable expectation of significant improvement in function will not materialize.

(9) "Speech therapy services" means the practice of speech-language pathology as defined in 37-15-102, MCA. For purposes of ARM 37.86.601, 37.86.605, 37.86.606, 37.86.610 and 46.12.529, speech therapy services do not include services provided by a hospital or home health agency.

(10) "Therapy services" or "therapies" means speech therapy services, occupational therapy services and physical therapy services. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 1996 MAR p. 1687, Eff. 6/21/96; AMD, 1998 MAR p. 676, Eff. 3/13/98; TRANS, from SRS, 2000 MAR p. 481.)

Rules 02 through 04 reserved

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37.86.605 THERAPY SERVICES, PROVIDER REQUIREMENTS

(1) These requirements are in addition to those contained in rule provisions generally applicable to medicaid providers.

(2) As a condition of participation in the Montana medicaid program, a therapist must:

(a) maintain a current license issued by the applicable Montana licensing board for the category of therapy being provided, or, if the provider is serving recipients outside the state of Montana, maintain a current license in the equivalent category under the laws of the state in which the services are provided;

(b) enter into and maintain a current provider enrollment form under the provisions of ARM 37.85.402 with the department's fiscal agent to provide the category of therapy services being provided.

(3) An assistant/aide may not enroll as a provider. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101 and 53-6-113, MCA; NEW, 1996 MAR p. 1687, Eff. 6/21/96; AMD, 1998 MAR p. 676, Eff. 3/13/98; TRANS, from SRS, 2000 MAR p. 481.)

37.86.606 THERAPY SERVICES, SERVICE REQUIREMENTS AND RESTRICTIONS (1) The requirements and restrictions in this rule apply for purposes of coverage and reimbursement of therapy services under the Montana medicaid program.

(2) Except as otherwise provided by these rules, therapy services must be provided by a therapist or assistant/aide within the scope of practice permitted by state law. The provider's records maintained under ARM 37.85.414 must demonstrate compliance with applicable supervision and protocol requirements.

(a) services provided by an assistant/aide may only be billed by a supervising therapist.

(3) Therapy services may be provided to a recipient only upon a current written or verbal order or referral by a physician or mid-level practitioner. All verbal orders or referrals must be followed up by a written order received by the provider within 30 days of the verbal order or referral.

(a) The provider is not entitled to medicaid reimbursement if services are provided prior to actual receipt of the written or verbal order or referral. Referral and orders are valid for medicaid purposes for no more than 180 days.

(b) The provider must maintain the referral or order of the physician or mid-level practitioner and appropriate records that demonstrate compliance with medicaid requirements. The provider must provide copies of these documents at no charge to the department or its agents upon request.

(4) Services that do not require the performance or supervision of a licensed therapist are not reasonable and necessary even if the services are performed by or under the supervision of a licensed therapist.

(5) Maintenance therapy services are not covered or reimbursable under the Montana medicaid program.

(a) Establishment of a maintenance therapy plan by a licensed therapist is reimbursable. Establishment of a maintenance plan includes the initial evaluation of the recipient's needs, development of a plan that incorporates the treatment objectives of the prescribing physician or mid-level practitioner and that is appropriate for the recipient's capacity and tolerance, instruction of others in carrying out the plan and further evaluations by a licensed therapist as required.

(6) Medicaid reimbursement for therapy service procedures includes all related supplies and items used in the performance of the service, except that the design, fabrication, fitting and instruction by a licensed therapist in the use of splints, braces and slings are reimbursable as provided in ARM 37.86.1801 through 37.86.1807.

(7) The following limits apply to therapy services:

(a) Occupational therapy services are limited to 40 hours per state fiscal year per recipient. Individuals age 21 or older are not eligible to receive additional hours over 40.

(b) Speech therapy services are limited to 40 hours of service per state fiscal year per recipient. Individuals age 21 or older are not eligible to receive additional hours over 40.

(i) One unit is equal to one visit code or four 15-minute increment codes as provided in the CPT.

(c) Physical therapy services are limited to 40 hours of service per state fiscal year per recipient. Individuals age 21 or older are not eligible to receive additional hours over 40. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1996 MAR p. 1687, Eff. 6/21/96; AMD, 1998 MAR p. 676, Eff. 3/13/98; TRANS, from SRS, 2000 MAR p. 481; EMERG, AMD, 2003 MAR p. 999, Eff. 5/9/03.)

Rules 07 through 09 reserved

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37.86.610 THERAPIES, REIMBURSEMENT (1) Providers must bill for services using the procedure codes and modifiers set forth, and according to the definitions contained, in the health care financing administration's common procedure coding system (HCPCS). Information regarding billing codes, modifiers and HCPCS is available upon request from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(2) Subject to the requirements of this rule, the Montana medicaid program pays the following for therapy services:

(a) For patients who are eligible for medicaid, the lower of:

(i) the provider's usual and customary charge for the service; or

(ii) 90% of the reimbursement provided in accordance with the methodologies described in ARM 37.85.212. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1996 MAR p. 1687, Eff. 6/21/96; AMD, 1997 MAR p. 1269, Eff. 7/22/97; AMD, 1998 MAR p. 676, Eff. 3/13/98; TRANS, from SRS, 2000 MAR p. 481; AMD, 2001 MAR p. 1476, Eff. 8/10/01; AMD, 2001 MAR p. 2156, Eff. 10/26/01.)

Subchapter 7

Audiology Services

37.86.701 AUDIOLOGY SERVICES, PROVIDER REQUIREMENTS

(1) These requirements are in addition to those contained in rule provisions generally applicable to medicaid providers.

(2) Audiology service providers, as a condition of participation in the Montana medicaid program, must:

(a) maintain a current audiology license issued by the Montana board of speech-language pathologists and audiologists, or, if the provider is serving recipients outside the state of Montana, maintain a current license in the equivalent category under the laws of the state in which the services are provided;

(b) enter into and maintain a current provider enrollment form under the provisions of ARM 37.85.402 with the department's fiscal agent to provide audiology services. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1996 MAR p. 1687, Eff. 6/21/96; TRANS, from SRS, 2000 MAR p. 481.)

37.86.702 AUDIOLOGY SERVICES, SERVICE REQUIREMENTS AND RESTRICTIONS (1) The following requirements and restrictions apply for purposes of coverage and reimbursement of audiology services under the Montana medicaid program.

(2) Audiology services are hearing aid evaluations and basic audio assessments provided within the scope of practice permitted by state law to recipients with hearing disorders. Audiology services must be provided by a licensed practitioner within the scope of the practice permitted by state law. The provider's records maintained under ARM 37.85.414 must demonstrate the medical necessity for the service, and compliance with applicable supervision and protocol requirements.

(a) Medicaid coverage and reimbursement for dispensing of hearing aids is available to licensed hearing aid dispensers, subject to the requirements of ARM 37.86.801 through 37.86.805 and the requirements generally applicable to medicaid providers.

(3) Audiology services may be provided to a recipient only upon a current written or verbal order or referral by a physician or mid-level practitioner. All verbal orders or referrals must be followed up by a written order received by the provider within 30 days of the verbal order or referral.

(a) The provider is not entitled to medicaid reimbursement if services are provided prior to actual receipt of the written or verbal order or referral. Referrals and orders are valid for medicaid purposes for no more than 90 days.

(b) The provider must maintain the referral or order of the physician or mid-level practitioner and appropriate records that demonstrate compliance with medicaid requirements. The provider must provide copies of these documents at no charge to the department or its agents upon request.

(4) In addition to the requirements of ARM 37.85.414, a provider must maintain the written orders of the physician or mid-level practitioner and all diagnostic and evaluative reports. The provider must provide copies of these documents at no charge to the department or its agents upon request.

(5) The audiology services must be required as preliminary steps to obtaining a medically necessary hearing aid or device for the recipient.

(6) Basic audio assessments must include for each ear under earphones:

(a) Pure tone air conduction thresholds at the frequencies of .5, 1, 2, 3 and 4 KHZ;

(b) Speech reception threshold; and

(c) Speech discrimination (word recognition) test under PB max conditions, and either pure tone bone conduction thresholds at the frequencies specified in (6)(a), or tympanometry, including tympanogram, acoustic reflexes and static compliance. A hearing aid fitting must include either sound field testing in an appropriate acoustic environment or real ear measurements to determine adequacy of fit of the hearing aid for the recipient's needs. A hearing aid fitting must include at least one followup visit and warranty coverage for the hearing aid for a period of at least 2 years.

(7) A hearing aid fitting must include either sound field testing in an appropriate acoustic environment or real ear measurements to determine adequacy of fit of the hearing aid for the recipient's needs. A hearing aid fitting must include at least one follow-up visit and warranty coverage for the hearing aid for a period of at least 2 years.

(8) Medicaid reimbursement for a basic audio assessment or a hearing aid evaluation includes all related supplies and items used in the performance of the assessment or evaluation. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1996 MAR p. 1687, Eff. 6/21/96; TRANS, from SRS, 2000 MAR p. 481.)

Rules 03 and 04 reserved

37.86.705 AUDIOLOGY SERVICES, REIMBURSEMENT

(1) Providers must bill for services using the procedure codes and modifiers set forth, and according to the definitions contained in the health care financing administration's common procedure coding system (HCPCS). Information regarding billing codes, modifiers and HCPCS is available upon request from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(2) Subject to the requirements of this rule, the Montana medicaid program pays the following for audiology services:

(a) For patients who are eligible for medicaid, the lower of:

(i) the provider's usual and customary charge for the service; or

(ii) 90% of the reimbursement provided in accordance with the methodologies described in ARM 37.85.212. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1996 MAR p. 1687, Eff. 6/21/96; AMD, 1997 MAR p. 1269, Eff. 7/22/97; AMD, 1998 MAR p. 676, Eff. 3/13/98; TRANS, from SRS, 2000 MAR p. 481; AMD, 2001 MAR p. 1476, Eff. 8/10/01; AMD, 2001 MAR p. 2156, Eff. 10/26/01.)

Subchapter 8

Hearing Aid Services

37.86.801 HEARING AID SERVICES, DEFINITIONS (1) "Hearing aid" means an instrument or device designed for or represented as aiding or improving defective human hearing and includes the parts, attachments or accessories of the instrument or device.

(2) "Hearing aid dispenser" or "dispenser" means a person holding a current license issued by the Montana board of hearing aid dispensers under Title 37, chapter 16, MCA to engage in selling, dispensing or fitting hearing aids. The term does not include any person to the extent that the person acts beyond the scope of the person's hearing aid dispenser license. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-141, MCA; NEW, 1980 MAR p. 973, Eff. 3/14/80; AMD, 1998 MAR p. 2168, Eff. 8/14/98; TRANS, from SRS, 2000 MAR p. 481.)

37.86.802 HEARING AID SERVICES, REQUIREMENTS AND LIMITATIONS (1) These requirements are in addition to those contained in rule provisions generally applicable to medicaid providers.

(2) Medicaid payment for purchase or rental of hearing aids will be made only to a licensed hearing aid dispenser for medicaid covered services provided in accordance with all applicable medicaid requirements and within the scope of practice permitted under the dispenser's license.

(3) A hearing aid may be covered under the medicaid program if:

(a) the recipient has been referred by a physician or mid-level practitioner for an audiological examination and the physician or mid-level practitioner has determined that there is no medical reason for which a hearing aid would not be effective in correcting the recipient's hearing loss;

(b) the examination by a licensed audiologist results in a determination that a hearing aid or aids are needed; and

(c) the following criteria are met:

(i) for persons over 21 years of age, the audiological examination results show that there is an average pure tone loss of at least 40 decibels for each of the frequencies of 500, 1,000, 2,000 and 3,000 Hertz in the better ear and word recognition or speech discrimination scores obtained at a level to ensure pb max. The following criteria shall apply to adults aged 21 years or older for binaural hearing aids:

(A) the two frequency average at 1khz and 2khz must be greater than 40db in both ears;

(B) the two frequency average at 1khz and 2khz must be less than 90db in both ears;

(C) the two frequency average at 1khz and 2khz must have an interaural difference of less than 15db;

(D) the interaural word recognition or speech discrimination score must have a difference of not greater than 20%;

(E) demonstrated success in using a monaural hearing aid for at least 6 months; and

(F) documented need to understand speech with a high level comprehension based on an educational or vocational need.

(ii) for persons under 21 years of age, the department or its designee determines after review of the audiology report that the hearing aid would be appropriate for the person. Persons under 21 years of age will be evaluated under the early periodic screening and testing program.

(d) the original hearing aid no longer meets the needs of the individual, and a new hearing aid is determined to be medically necessary by a licensed audiologist.

(4) The audiologist shall indicate in a written report whether in his or her professional opinion a hearing aid is required for the recipient. The report shall also indicate the type of hearing aid required by the recipient and whether monaural or binaural hearing aids are required. The audiologist's report will be prepared in accordance with the format described in the audiologists' provider manual.

(5) A claim for coverage of a hearing aid must be approved in writing by the department or its designee prior to the provision of the service. Copies of the physician's referral and audiologist's report must be submitted with the claim.

(6) The date of service is defined as the date the hearing aid(s) is ordered by the dispenser.

(7) For individuals age 21 or over, a hearing aid purchased by medicaid will be replaced no more than once in a 5 year period and only if:

(a) the original hearing aid has been irreparably broken after the 1 year warranty period or has been lost;

(b) the provider's records document the loss or broken condition of the original hearing aid; and

(c) the hearing loss criteria specified in this rule continue to be met. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-141, MCA; NEW, 1980 MAR p. 973, Eff. 3/14/80; AMD, 1987 MAR p. 895, Eff. 7/1/87; AMD, 1988 MAR p. 596, Eff. 3/25/88; AMD, 1988 MAR p. 758, Eff. 4/15/88; AMD, 1990 MAR p. 1326, Eff. 7/13/90; AMD, 1998 MAR p. 2168, Eff. 8/14/98; AMD, 1999 MAR p. 1379, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 481.)

Rules 03 and 04 reserved

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37.86.805 HEARING AID SERVICES, REIMBURSEMENT (1) The department will pay the lower of the following for covered hearing aid services and items:

(a) the provider's reasonable usual and customary charge for the service or item;

(b) the amount specified for the particular service or item in the department's fee schedule. The department adopts and incorporates by reference the department's fee schedule dated January 2005 which sets forth the reimbursement rates for hearing aid services. A copy of the department's fee schedule may be obtained from the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(2) The provider may bill medicaid for a dispensing fee, as specified in the fee schedule adopted in (1)(b), in addition to the invoice price for the purchase of a hearing aid or aids. The dispensing fee covers and includes the initial ordering, fitting, orientation, counseling, two return visits for the services listed, and the insurance for loss or damages covered under a one year warranty. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-113 and 53-6-141, MCA; NEW, 1980 MAR p. 973, Eff. 3/14/80; AMD, 1981 MAR p. 559, Eff. 6/12/81; AMD, 1981 MAR p. 1975, Eff. 1/1/82; AMD, 1982 MAR p. 1289, Eff. 7/1/82; AMD, 1988 MAR p. 596, Eff. 3/25/88; AMD, 1989 MAR p. 859, Eff. 6/30/89; AMD, 1990 MAR p. 1326, Eff. 7/13/90; AMD, 1998 MAR p. 2168, Eff. 8/14/98; AMD, 1999 MAR p. 1379, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 1664 Eff. 6/30/00; AMD, 2002 MAR p. 1779, Eff. 6/28/02; AMD, 2003 MAR p. 1314, Eff. 7/1/03; AMD, 2005 MAR p. 385, Eff. 3/18/05.)

Subchapter 9 reserved

Subchapter 10

Dental Services

37.86.1001 DENTAL SERVICES, DEFINITIONS For purposes of this subchapter, the following definitions apply:

(1) "Dental service" means medically necessary treatment of the teeth and associated structures of the oral cavity. Dental service includes the provision of orthodontia and prostheses.

(2) "Relative values for dentists (RVD) scale" means the scale published biennially by Relative Value Studies Inc., 1675 Larimer, Suite 410, Denver, CO 80202, listing the relative value of dental services provided by dentists and denturists.

(3) "Relative value unit (RVU)" means a numerical value assigned in the resource based relative value scale to each procedure code for which a relative value is available. The RVD is a comprehensive relative value system that lists dental procedures used by dentists and denturists as an expression of the relative effort and expense expended by a provider in providing one service as compared to another service. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-141, MCA; NEW, 1980 MAR p. 1747, Eff. 6/27/80; AMD, 1985 MAR p. 1410, Eff. 9/27/85; AMD, 1999 MAR p. 1522, Eff. 7/2/99; TRANS, from SRS, 2000 MAR p. 481; AMD, 2001 MAR p. 1117, Eff. 6/22/01.)

37.86.1002 DENTAL SERVICES, REQUIREMENTS (1) These requirements are in addition to those rule provisions generally applicable to medicaid providers and the provision of services under medicaid coverage.

(2) Medicaid reimbursement for dental care is limited to those services specified in ARM 37.86.1006. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-141, MCA; NEW, 1980 MAR p. 1747, Eff. 6/27/80; AMD, 1982 MAR p. 301, Eff. 2/12/82; AMD, 1985 MAR p. 1410, Eff. 9/27/85; AMD, 1987 MAR p. 895, Eff. 7/1/87; AMD, 1988 MAR p. 286, Eff. 3/1/88; AMD, 1988 MAR p. 758, Eff. 4/15/88; AMD, 1988 MAR p. 1995, Eff. 9/9/88; AMD, 1990 MAR p. 1331, Eff. 7/13/90; AMD, 1993 MAR p. 2433, Eff. 10/15/93; AMD, 1999 MAR p. 1522, Eff. 7/2/99; TRANS, from SRS, 2000 MAR p. 481.)

Rule 03 reserved

37.86.1004 REIMBURSEMENT METHODOLOGY FOR SOURCE BASED RELATIVE VALUE FOR DENTISTS (1) For procedures listed in the relative values for dentists scale, reimbursement rates shall be determined using the following methodology:

(a) The fee for a covered service shall be the amount determined by multiplying the relative value unit specified in the relative values for dentists scale by the conversion factor specified in (1)(b) or (c). The department adopts and incorporates by reference the relative values for dentists scale published in 2004 for use in 2005 and 2006. Copies of the relative values for dentists scale are available upon request from the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(b) The conversion factor used to determine the medicaid payment amount for services provided to eligible individuals age 18 and above is $21.77.

(c) The conversion factor used to determine the medicaid payment amount for services provided to eligible individuals age 17 and under is $28.30. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 2001 MAR p. 1117, Eff. 6/22/01; AMD, 2002 MAR p. 1780, Eff. 6/28/02; EMERG, AMD, 2002 MAR p. 2665, Eff. 9/27/02; AMD, 2003 MAR p. 1314, Eff. 7/1/03; AMD, 2005 MAR p. 1073, Eff. 7/1/05.)

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37.86.1005 DENTAL SERVICES, REIMBURSEMENT (1) For dental services listed in the RVD scale, the department shall pay the lowest of the following for dental services covered by the medicaid program:

(a) the provider's usual and customary charge for the service;

(b) the amount determined using the methodology described in ARM 37.86.1004.

(2) For dental services that are not listed in the RVD scale, the department shall pay the lowest of the following for dental services covered by the medicaid program:

(a) the provider's usual and customary charge;

(b) the amount determined using the by-report method as follows:

(i) for covered dental services provided to persons age 18 and over, 65.2% of the provider's usual and customary charge for the service;

(ii) for covered dental services provided to persons age 17 and under, 80% of the provider's usual and customary charge for the service.

(3) Reimbursement for services delivered to adults is the fee specified in the fee schedule or, if reimbursement is based on the "by report" method, 65.2% of the provider's usual and customary charge for the service. Services delivered to adults are services provided while the recipient is age 21 and over.

(4) Reimbursement for services delivered to a child is the fee specified in the fee schedule or, if reimbursement is based on the "by report" method, 80% of the provider's usual and customary charge for the service. Services delivered to children are services provided while the recipient is up to and including age 17.

(5) Reimbursement for services delivered to individuals age 18 through 20 is the fee specified in the fee schedule for adults, or if reimbursement is based on the "by report" method 80% of the provider's usual and customary charge for the service.

(6) No extra fee for pulp capping or bases is reimbursable.

(7) Payment for denture adjustments during the 1st year after delivery of the dentures is available only to a dentist or denturist who did not make the dentures.

(8) Medical procedures, within the scope of practice for licensed dentists, that are not listed in the dental services provider manual are reimbursed in accordance with the methodologies provided in ARM 37.85.212 and 37.86.105.

(9) A dentist examining more than one medicaid recipient in a long-term care facility on the same day is allowed payment for one nursing home call in addition to the examination fees. Examination is considered a recorded evaluation.

(10) Payment for orthodontia will be as follows:

(a) Full band orthodontia for medicaid recipients who have cleft lip/palate, craniofacial anomalies or malocclusions caused by traumatic injury and interceptive orthodontia for medicaid recipients who have posterior crossbite with shift, anterior crossbite and/or anterior deep bite at 80% or greater vertical incisor overbite, will be reimbursed at 85% of the provider's usual and customary charge, subject to the maximum allowable charge as published in the department's orthodontic coverage and reimbursement guidelines, December 1999.

(b) Payment will be based upon a treatment plan submitted by the provider which will include at a minimum, a description of the plan of treatment, estimated usual and customary charge and time line for treatment. The department will reimburse 40% of the medicaid allowed amount up front for application of appliances, the remainder being paid in monthly installments as determined by the time line defined in the provider's treatment plan for completing orthodontic care.

(c) Recipients are limited to an overall lifetime cap of $7000.00 for interceptive and full band orthodontia phases unless otherwise provided by these rules. Services included in the separate phases including monthly visits, are as listed in the department's orthodontic coverage and reimbursement guidelines. Surgeries are not included in this lifetime cap.

(d) Maximum allowable charges for each phase of orthodontic treatment, time lines for orthodontic phases of care, and the services included in each phase of orthodontic care are listed in the department's orthodontic coverage and reimbursement guidelines. The department hereby adopts and incorporates herein by reference the department's orthodontic coverage and reimbursement guidelines updated through December 1999. The guidelines, issued by the department to all providers of orthodontic services, inform providers of the requirements applicable to the delivery of services. A copy of the department's orthodontic coverage and reimbursement guidelines is available from the Department of Public Health and Human Services, Health Policy and Services Division, Medicaid Services Bureau, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-113 and 53-6-141, MCA; NEW, 1980 MAR p. 1752, Eff. 6/27/80; AMD, 1981 MAR p. 559, Eff. 6/12/81; AMD, 1981 MAR p. 1975, Eff. 1/1/82; AMD, 1982 MAR p. 301, Eff. 2/12/82; AMD, 1982 MAR p. 1289, Eff. 7/1/82; AMD, 1985 MAR p. 1410, Eff. 9/27/85; AMD, 1987 MAR p. 895, Eff. 7/1/87; AMD, 1988 MAR p. 286, Eff. 3/1/88; AMD, 1988 MAR p. 758, Eff. 4/15/88; AMD, 1988 MAR p. 1995, Eff. 9/9/88; AMD, 1989 MAR p. 859, Eff. 6/30/89; AMD, 1990 MAR p. 1331, Eff. 7/13/90; AMD, 1990 MAR p. 1479, Eff. 7/27/90; AMD, 1993 MAR p. 2433, Eff. 10/15/93; AMD, 1995 MAR p. 1968, Eff. 10/1/95; AMD, 1999 MAR p. 1522, Eff. 7/2/99; AMD, 1999 MAR p. 2898, Eff. 12/17/99; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 1664, Eff. 6/30/00; AMD, 2001 MAR p. 1117, Eff. 6/22/01.)

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37.86.1006 DENTAL SERVICES, COVERED PROCEDURES (1) For purposes of specifying coverage of dental services through the medicaid program, the department incorporates by reference the dental and denturist services provider manual effective July 2005. The dental and denturist services provider manual, provided to providers of those services, informs the providers of the requirements applicable to the delivery of services. Copies of the manual are available on the medicaid provider website at www.dphhs.mt.gov and from the Department of Public Health and Human Services, Health Resources Division, Medicaid Services Bureau, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(2) Dentists may bill medical "CPT" procedure codes as provided in ARM 37.85.212 and 37.86.101 for any medicaid covered medical procedure which they are allowed to provide under the Dental Practice Act that is not otherwise listed in the dental services provider manual.

(3) All services which require prior authorization from the designated review organization are identified in the department's fee schedule. Reimbursement is not provided for such services unless prior authorization has been given by the designated review organization.

(4) Coverage of denture services are subject to the following requirements and limitations:

(a) a denturist may provide initial immediate full prosthesis and initial immediate partial prosthesis only when prescribed by a dentist; and

(b) requests for full prosthesis must show the approximate date of the most recent extractions, and/or the age and type of the present prosthesis.

(5) Replacement of lost dentures is a covered service subject to the following requirements and limitations:

(a) the dentist or denturist must indicate "lost dentures" on the request for prior authorization for replacement;

(b) full dentures which are over 10 years old may be replaced when the treating dentist documents the need for replacement;

(c) partial dentures which are over five years old may be replaced with full dentures;

(d) dentures which are between five and 10 years old may be replaced when the treating dentist documents the need for replacement, but reimbursement is at the rate for duplicating (or jumping) the dentures;

(e) the limits on coverage of denture replacement may be exceeded when the designated review organization determines that the existing dentures are causing the recipient serious physical health problems; and

(f) replacement of a lost denture is limited to one replacement per recipient per lifetime.

(6) Orthodontia for recipients age 21 and older who have maxillofacial anomalies that must be corrected surgically and for which the orthodontia is a necessary adjunct to the surgery is a covered service.

(7) Full band orthodontia for recipients 21 and younger who have malocclusion caused by traumatic injury or needed as part of treatment for a medical condition with orthodontic implications are covered in the department's orthodontic coverage and reimbursement guidelines, published December 1999. The department adopts and incorporates by reference the department's orthodontic coverage and reimbursement guidelines updated through December 1999. The guidelines, issued by the department to all providers of orthodontic services, informs providers of the requirements applicable to the delivery of services. A copy of the department's orthodontic coverage and reimbursement guidelines is available from the Department of Public Health and Human Services, Health Resources Division, Medicaid Services Bureau, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(8) Unless otherwise provided by these rules, interceptive orthodontia is limited to children 12 years of age or younger with one or more of the following conditions:

(a) posterior crossbite with shift;

(b) anterior crossbite.

(9) All full band orthodontia for cleft lip/palate, congenital anomalies, cases related to malocclusion caused by traumatic injury and cases related to interceptive orthodontia must receive prior authorization from the department's designated peer reviewer to determine individual eligibility for such orthodontia services.

(10) Orthodontic treatment not progressing to the extent of the treatment plan because of noncompliance by the recipient and which jeopardizes the health of the recipient may result in termination of orthodontic treatment. If termination of orthodontic treatment occurs because of noncompliance by the recipient, medicaid will not authorize any future orthodontic requests for that recipient.

(11) Cosmetic dentistry is not a covered service of the medicaid program.

(12) Dental implants are not a covered benefit of the medicaid program.

(13) Covered services for adults age 21 and over include:

(a) diagnostic;

(b) preventative;

(c) basic restorative services including stainless steel crowns; and

(d) extractions.

(14) Tooth colored crowns and bridges are not covered benefits of the medicaid program for individuals age 21 and over. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 1990 MAR p. 1331, Eff. 7/13/90; AMD, 1993 MAR p. 2433, Eff. 10/15/93; AMD, 1995 MAR p. 1968, Eff. 10/1/95; AMD, 1999 MAR p. 1522, Eff. 7/2/99; AMD, 1999 MAR p. 2898, Eff. 12/17/99; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 1664, Eff. 6/30/00; AMD, 2002 MAR p. 1780, Eff. 6/28/02; AMD, 2005 MAR p. 1073, Eff. 7/1/05.)

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Subchapter 11

Outpatient Drug Services

37.86.1101 OUTPATIENT DRUGS, DEFINITIONS (1) "Estimated acquisition cost (EAC)" means the cost of drugs for which no maximum allowable cost (MAC) price has been determined. The EAC is the department's best estimate of what price providers are generally paying in the state for a drug in the package size providers buy most frequently. The EAC for a drug is:

(a) the direct price (DP) charged by manufacturers to retailers;

(b) if there is no available DP for a drug or the department determines that the DP is not available to providers in the state, the EAC is the average wholesale price (AWP) less 15%; or

(c) the department may set an allowable acquisition cost for specified drugs or drug categories when the department determines that acquisition cost is lower than (1)(a) or (b) based on data provided by the drug pricing file contractor.

(2) "Legend drugs" means drugs that federal law prohibits dispensing without a prescription.

(3) "Maximum allowable cost (MAC)" means the upper limit the department will pay for multi-source drugs. In order to establish base prices for calculating the maximum allowable cost, the department hereby adopts and incorporates by reference the methodology for limits of payment set forth in 42 CFR 447.331 and 447.332 (1996). The maximum allowable cost for multi-source drugs will not exceed the total of the dispensing fee established by the department and an amount that is equal to the price established under the methodology set forth in 42 CFR 447.331 and 447.332 for the least costly therapeutic equivalent that can be purchased by pharmacists in quantities of 100 tablets or capsules or, in the case of liquids, the commonly listed size. If the drug is not commonly available in quantities of 100, the package size commonly listed will be the accepted quantity. A copy of the above-cited regulations may be obtained from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT, 59620-2951.

(4) "Outpatient drugs" means drugs which are obtained outside of a hospital. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1998 MAR p. 495, Eff. 2/13/98; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 2313, Eff. 8/25/00; AMD, 2002 MAR p. 1788, Eff. 6/28/02.)

37.86.1102 OUTPATIENT DRUGS, REQUIREMENTS (1) These requirements are in addition to those contained in ARM 37.85.401 through 37.85.415.

(2) Drugs may not be filled or refilled without the authorization of the physician or other licensed practitioner who is authorized by law to prescribe drugs and is recognized by the medicaid program.

(3) The department will only participate in the payment of legend and over the counter drugs listed on the department drug formulary, as determined by the medicaid drug formulary committee established by the department. The formulary committee is the drug use review board, established and operating in accordance with 42 USC 1396r-8 (2004), which governs medicaid drug programs. The drug formulary includes a preferred drug list (PDL) of selected drugs that have a significant clinical benefit over other agents in the same therapeutic class and also represents good value to the department based on total cost. Prescribers must prescribe from the preferred drug list if medically appropriate.

(a) The PDL includes drugs subject to a centers for medicare and medicaid services (CMS) approved supplemental rebate agreement between the manufacturer and the department. Drugs in the same therapeutic class as those identified on the preferred drug list but not identified as a preferred drug are subject to prior authorization as outlined in (6)(c).

(4) The inappropriate use of drugs, as determined by professional review, may result in the imposition of a limitation upon the quantities of medications which are payable by the medical assistance program. Retroactive limitation will not be applied, unless the involved pharmacy has knowledge or can reasonably be expected to have had knowledge of the inappropriate use of drugs by the recipient.

(5) Each prescription shall be dispensed in the quantity ordered except that:

(a) Prescriptions for which a specific quantity has not been ordered shall be dispensed in sufficient quantities to cover the period of time for which the condition is being treated except for injectable antibiotics, which may be dispensed in sufficient quantities to cover a three-day period.

(b) Notwithstanding the above, prescriptions may not be dispensed in quantities greater than a 34-day supply.

(6) The department will not participate in the payment of a prescription drug:

(a) which the secretary of health and human services (HHS) has determined is less than effective for all conditions of use prescribed, recommended or suggested in the drug's labeling;

(b) that is not subject to a rebate agreement between the manufacturer and the secretary of HHS as required by 42 USC 1396r-8 (2004); and

(c) that does not meet prior authorization criteria as determined by the medicaid drug formulary committee, established and operating in accordance with 42 USC 1396r-8 (2004), without the existence of a prior authorization request approved by the department or its designated representative. A list of drugs subject to prior authorization, known as the prior authorization drug list, will be provided to interested medicaid providers.

(7) The drug formulary, PDL and the prior authorization drug list will be updated by the department on a monthly basis, on the last day of each month. A copy of the most current listings may be obtained from the department website at www.dphhs.state.mt.us, or by writing to the Department of Public Health and Human Services, Health Resources Division (HRD), Acute Services Bureau, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(8) The department hereby adopts and incorporates by reference 42 USC 1396r-8 (2004) as a part of these rules. This section of the federal law sets forth the requirements that must be met by the department, drug manufacturers and providers in order to receive reimbursement for outpatient drugs that have been dispensed. This statute describes rebate agreements, covered drugs, prior authorization, reimbursement limits and drug use review programs. A copy of 42 USC 1396r-8 (2004) can be obtained by writing to the Department of Public Health and Human Services, Health Resources Division (HRD), Acute Services Bureau, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(9) The department will use the following procedures to develop the preferred drug list (PDL):

(a) The department will perform a pharmacoeconomic analysis of the medicaid pharmacy program and identify therapeutic classes of drugs for possible PDL inclusion.

(b) The department and the drug use review (DUR) board/formulary committee members will consider recommendations and determine which therapeutic drug classes will be reviewed at a meeting of the committee. Notice of the meeting and the therapeutic drug class to be considered will be posted on the department's web site in advance of the meeting date.

(c) The department will perform drug class reviews using peer-reviewed literature, established evidence-based practice methods, and local clinicians to interpret and apply practical experience to the structured evidence reviews. The department will also conduct supplemental rebate negotiations.

(d) The committee will combine its members' evaluations and the evaluations from the department to consider equivalent products within the drug class. Information used by the department and its contractors will be available to the public prior to the meeting. During the meeting, the committee will also hear comments from interested parties.

(e) The committee will recommend to the department which preferred agents should be selected for the specific therapeutic class.

(f) The department will make a final decision and post its decision on the department's web site. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-113 and 53-6-141, MCA; NEW, 1980 MAR p. 2978, Eff. 11/29/80; AMD, 1982 MAR p. 105, Eff. 1/29/82; AMD, 1987 MAR p. 895, Eff. 7/1/87; AMD, 1988 MAR p. 753, Eff. 5/1/88; AMD, 1991 MAR p. 1039, Eff. 6/28/91; AMD, 1994 MAR p. 2443, Eff. 8/26/94; AMD, 1998 MAR p. 495, Eff. 2/13/98; TRANS, from SRS, 2000 MAR p. 481; EMERG, AMD, 2003 MAR p. 999, Eff. 5/9/03; AMD, 2004 MAR p. 1489, Eff. 7/2/04.)

Rules 03 and 04 reserved

37.86.1105 OUTPATIENT DRUGS, REIMBURSEMENT (1) Drugs will be paid for on the basis of the Montana "estimated acquisition cost" or the "maximum allowable cost", plus a dispensing fee established by the department, or the provider's "usual and customary charge", whichever is lower; except that the "maximum allowable cost" limitation shall not apply in those cases where a physician or other licensed practitioner who is authorized by law to prescribe drugs and is recognized by the medicaid program certifies in their own handwriting that in their medical judgement a specific brand name drug is medically necessary for a particular patient. An example of an acceptable certification would be the notation "brand necessary" or "brand required". A check-off box on a form or a rubber stamp is not acceptable.

(2) The dispensing fee for filling prescriptions shall be determined for each pharmacy provider annually.

(a) The dispensing fee is based on the pharmacy's average cost of filling a prescription. The average cost of filling a prescription will be based on the direct and indirect costs that can be allocated to the cost of the prescription department and that of filling a prescription, as determined from the Montana dispensing fee questionnaire. A provider's failure to submit, upon request, the dispensing fee questionnaire properly completed will result in the assignment of the minimum dispensing fee offered. A copy of the Montana dispensing fee questionnaire is available upon request from the department.

(b) The dispensing fees assigned shall range between a minimum of $2.00 and a maximum of $4.70.

(c) Out-of-state providers will be assigned a $3.50 dispensing fee.

(d) If the individual provider's usual and customary average dispensing fee for filling prescription is less than the foregoing method of determining the dispensing fee, then the lesser dispensing fee shall be applied in the computation of the payment to the pharmacy provider.

(3) In-state pharmacy providers that are new to the Montana medicaid program will be assigned an interim $3.50 dispensing fee until a dispensing fee questionnaire, as provided in (2) above, can be completed for six months of operation. At that time, a new dispensing fee will be assigned which will be the lower of the dispensing fee calculated in accordance with (2) for the pharmacy or the $4.70 dispensing fee. Failure to comply with the six months dispensing fee questionnaire requirement will result in assignment of a dispensing fee of $2.00.

(4) "Unit dose" prescriptions will be paid by a separate dispensing fee of $0.75. This "unit dose" dispensing fee will offset the additional cost of packaging supplies and materials which are directly related to filling "unit dose" prescriptions by the individual pharmacy and is in addition to the regular dispensing fee allowed. Only one unit dose dispensing fee will be allowed each month for each prescribed medication. A dispensing fee will not be paid for a unit dose prescription packaged by the drug manufacturer.

(5) Reimbursement for outpatient drugs provided to medicaid recipients in state institutions shall be as follows:

(a) for institutions participating in the state contract for pharmacy services, the rates agreed to in that contract. Such reimbursement shall not exceed, in the aggregate, reimbursement under (1); or

(b) for institutions not participating in the state contract for pharmacy services, the actual cost of the drug and dispensing fee. Such reimbursement shall not exceed, in the aggregate, reimbursement under (1). (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-113 and 53-6-141, MCA; NEW, 1980 MAR p. 2978, Eff. 11/29/80; AMD, 1983 MAR p. 607, Eff. 5/27/83; AMD, 1986 MAR p. 1967, Eff. 12/1/86; AMD, 1987 MAR p. 895, Eff. 7/1/87; AMD, 1988 MAR p. 753, Eff. 5/1/88; AMD, 1989 MAR p. 879, Eff. 7/1/89; AMD, 1990 MAR p. 1481, Eff. 7/27/90; AMD, 1998 MAR p. 495, Eff. 2/13/98; AMD, 1998 MAR p. 2168, Eff. 8/14/98; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 3176, Eff. 11/10/00; AMD, 2002 MAR p. 1788, Eff. 6/28/02.)

Subchapters 12 and 13 reserved

Subchapter 14

Ambulatory Surgical Centers

37.86.1401 CLINIC SERVICES, DEFINITIONS (1) "Clinic services" means preventive diagnostic, therapeutic, rehabilitative, or palliative items or services provided under the direction of a physician by an outpatient facility that is not part of a hospital, but is organized and operated to provide medical care to outpatients independent of a hospital. Clinic services may be provided in surgical centers and public health departments. Clinic services do not include mental health center services as defined in ARM 37.88.901.

(2) "Ambulatory surgical center services" means clinic services which are provided in a licensed, freestanding ambulatory surgical center, but do not include physicians services, anesthesiologists services, ambulance services, or major prosthetic appliances such as intraocular lenses.

(3) "Class I anesthesia risk" means an individual with no detectable systemic diseases and no physical abnormalities which would in any way impair the functioning of his jaw, neck, airway, chest, or abdominal function.

(4) "Class II anesthesia risk" means an individual who has only one systemic disease which can potentially threaten the safe outcome of an anesthesia.

(5) "Public health department services" mean physician services and mid-level practitioner services as provided for in 50-2-116, 50-2-118, and 50-2-119, MCA.

(6) "Protocols" mean written plans developed by a public health clinic in collaboration with physician and nursing staff specifying the nursing procedures to be followed in giving a specific exam, or providing care for particular conditions. Protocols must be updated and approved by a physician at least annually. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-141, MCA; NEW, Eff. 11/4/74; AMD, 1982 MAR p. 1695, Eff. 9/17/82; AMD, 1989 MAR p. 877, Eff. 6/30/89; AMD, 1989 MAR p. 1850, Eff. 11/10/89; AMD, 1992 MAR p. 1404, Eff. 7/1/92; AMD, 1994 MAR p. 313, Eff. 2/11/94; AMD, 1997 MAR p. 548, Eff. 3/25/97; AMD, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 1664, Eff. 6/30/00.)

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37.86.1402 CLINIC SERVICES, REQUIREMENTS (1) These requirements are in addition to those requirements contained in ARM 37.85.401 through 37.85.414.

(2) Clinic services must be provided by a clinic which is licensed as an outpatient facility by the appropriate licensing entity of the state where the facility is located and meet the requirement for participation in medicare.

(3) Clinic services must be provided by, or under the direction of a licensed physician or, where appropriate a licensed dentist.

(4) Patients receiving ambulatory surgical center services must be either class I anesthesia risk or a class II anesthesia risk.

(5) Conditions for coverage of listed ambulatory surgical center procedures:

(a) Covered surgical procedures are limited to those procedures that do not generally exceed:

(i) a total of 90 minutes operating time; and

(ii) a total of 4 hours recovery or convalescent time.

(b) If the covered surgical procedure requires anesthesia, the anesthesia must be:

(i) local or regional anesthesia; or

(ii) general anesthesia of 90 minutes or less duration.

(c) Covered surgical procedures may not be of a type that:

(i) generally result in extensive blood loss;

(ii) requires a major or prolonged invasion of body cavities;

(iii) directly involves major blood vessels;

(iv) are generally emergency or life threatening in nature; or

(v) can safely be performed in a physician's or dentist's office.

(d) Covered surgical procedures can only be rendered by a licensed ambulatory surgical center.

(6) Public health department services consist of the following types of services:

(a) Mid-level practitioner services which:

(i) are provided through a public health department; and

(ii) meet all requirements specified in ARM 37.86.201, 37.86.202 and 46.12.2012.

(b) Physician services which:

(i) are provided either:

(A) directly by the physician; or

(B) by a public health nurse under a physician's immediate supervision. This means the physician has seen the patient and ordered the services except that a minimal service does not require the physician to see the patient. Minimal services are covered when provided by a licensed registered nurse under protocols provided by a physician affiliated with the public health department. Protocols shall be updated at least annually.

(ii) meet the requirements specified in ARM 37.86.105.

(7) Telephone contacts are not a clinic service. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-141, MCA; NEW, 1982 MAR p. 1695, Eff. 9/17/82; AMD, 1989 MAR p. 877, Eff. 6/30/89; AMD, 1989 MAR p. 1850, Eff. 11/10/90; AMD, 1990 MAR p. 740, Eff. 3/16/90; AMD, 1991 MAR p. 1032, Eff. 7/1/91; AMD, 1992 MAR p. 1404, Eff. 7/1/92; AMD, 1994 MAR p. 313, Eff. 2/11/94; AMD, 1997 MAR p. 548, Eff. 3/25/97; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 1664, Eff. 6/30/00.)

Rules 03 and 04 reserved

37.86.1405 CLINIC SERVICES, COVERED PROCEDURES

(1) Ambulatory surgical center (ASC) services:

(a) are services that will be covered by medicaid if provided in an outpatient ASC setting incident to provision of physician or dental services to the patient where the services and supplies are furnished in the ASC on a physician's or dentist's order by ASC personnel under the supervision of ASC medical staff;

(b) are limited as provided by ARM 37.86.1402(1) through (5) with the term clinic taken to mean ASC.

(2) Clinic services, covered by the medicaid program, include physician services covered in ARM 37.86.101, 37.86.104 and 37.86.105.

(3) Clinic services, covered by the medicaid program, include mid-level practitioner services covered in ARM 37.86.201, 37.86.202 and 37.86.205. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-141, MCA; NEW, 1982 MAR p. 1695, Eff. 9/17/82; AMD, 1989 MAR p. 877, Eff. 6/30/89; AMD, 1992 MAR p. 1404, Eff. 7/1/92; AMD, 1994 MAR p. 313, Eff. 2/11/94; AMD, 1997 MAR p. 548, Eff. 3/25/97; AMD, 1999 MAR p. 1516, Eff. 7/2/99; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 1664, Eff. 6/30/00.)

37.86.1406 CLINIC SERVICES, REIMBURSEMENT

(1) Ambulatory surgical center (ASC) services as defined in ARM 37.86.1401(2) provided by an ASC will be reimbursed on a fee basis as follows:

(a) 100% of the medicare allowable amount for rural counties. For purposes of determining the medicare allowable amount for ASC services to medicaid recipients under this rule, the department hereby adopts and incorporates herein by reference the methodology at 42 CFR part 416, subpart E (1997), and the schedule listing the allowable amounts for ASC services in rural counties found at Medicare Carriers Manual, section 5243. The cited authorities are federal regulations and manuals specifying the methods and rules used to determine reasonable cost for purposes of the medicare program. Copies of the cited authorities may be obtained from the Department of Public Health and Human Services, Health Policy and Services Division, P.O. Box 202951, Helena, MT 59620-2951.

(i) For purposes of applying the provisions of 42 CFR part 416, subpart E (1997), and the Medicare Carriers Manual, section 5243, any reference in such authorities to medicare, medicare beneficiary, beneficiary, intermediary or secretary shall be deemed to refer also to medicaid, medicaid recipient, recipient, the department or the department, respectively.

(ii) For state fiscal year 2003, fees determined in accordance with this rule shall be reduced by 2.6%.

(b) For ASC services where no medicare fee has been assigned, the fee is 55% of usual and customary charges.

(c) Except as provided in (1)(d), the payment specified in (1)(a) or (1)(b) is an all inclusive bundled payment per procedure or service which shall be deemed to cover all outpatient services provided to the patient, including but not limited to nursing, pharmacy, laboratory, imaging services, other diagnostic services, supplies and equipment and other ASC services. For purposes of ASC surgery services, a visit shall be deemed to include all ASC services related or incident to the ambulatory surgery visit that are provided the day before or the day of the ambulatory surgery event.

(d) Physician services are separately billable according to the applicable medicaid rules governing billing for physician services.

(e) When multiple procedures are performed at the same time on the same patient, the first procedure listed shall be paid as provided at (1)(a) or (1)(b) as appropriate. Subsequent procedures shall be paid at 50% of the amount provided at (1)(a) or (1)(b) as appropriate.

(2) Reimbursement for major prosthetic appliance shall be made in accordance with ARM 37.86.1806 and 37.86.1807.

(3) Public health department services are reimbursed at the lowest of the following:

(a) the fees established by the department; or

(b) reimbursement for either physician services, provided in accordance with the methodologies described in ARM 37.85.212 and 37.86.105, or mid-level practitioner services, provided in accordance with the methodologies described in ARM 37.85.212 and 37.86.205. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-141, MCA; NEW, 1982 MAR p. 1695, Eff. 9/17/82; AMD, 1989 MAR p. 877, Eff. 6/30/89; AMD, 1989 MAR p. 1850, Eff. 11/10/89; AMD, 1990 MAR p. 1479, Eff. 7/27/90; AMD, 1992 MAR p. 1404, Eff. 7/1/92; AMD, 1994 MAR p. 313, Eff. 2/11/94; AMD, 1997 MAR p. 548, Eff. 3/25/97; AMD, 1998 MAR p. 676, Eff. 3/13/98; AMD, 1999 MAR p. 1516, Eff. 7/2/99; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 1664, Eff. 6/30/00; AMD, 2001 MAR p. 1476, Eff. 8/10/01; AMD, 2001 MAR p. 2156, Eff. 10/26/01; EMERG, AMD, 2002 MAR p. 797, Eff. 3/15/02; EMERG, AMD, 2002 MAR 2665, Eff. 9/27/02.)

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Subchapter 15

Home Infusion Therapy Services

37.86.1501 HOME INFUSION THERAPY SERVICES, DEFINITIONS In ARM 37.86.1501, 37.86.1502, 37.86.1505 and 37.86.1506, the following definitions apply:

(1) "Agency staff services" means all services provided by the home infusion therapy agency's staff, including all professional and non-professional employed and contracted individuals. Agency staff services include:

(a) preparation and revision of the plan of care;

(b) coordination of treatment with other health care providers;

(c) recipient and/or care giver training;

(d) clinical monitoring of laboratory values and therapy progression;

(e) reporting clinical information to the recipient's physician and other health care providers;

(f) delivery, pick up and disposal of equipment, supplies or drugs;

(g) 24-hour on call status; and

(h) any other services provided by the agency staff related to the recipient's home infusion therapy services.

(2) "Home infusion therapy services" means a comprehensive treatment program for the preparation and administration of parenteral medications or parenteral or enteral nutritional services to a recipient who is not receiving infusion therapy as a hospital inpatient or outpatient. Home infusion therapy services include all pharmacist professional services, all agency staff services and all associated medical equipment and supplies. Home infusion therapy services do not include professional nursing services, professional physician services or drugs.

(3) "Pharmacist professional services" include:

(a) preparation and revision of the plan of care;

(b) preparation and compounding of drugs;

(c) monitoring of laboratory values and therapy progression;

(d) reporting clinical information to the recipient's physician and other health care providers;

(e) delivery, pick up and disposal of equipment, supplies and/or drugs;

(f) 24-hour on call status; and

(g) any other services of the pharmacist related to the recipient's home infusion therapy services. Pharmacist professional services do not include costs, fees or charges for the drugs that are compounded or administered. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 1996 MAR p. 2599, Eff. 10/4/96; TRANS, from SRS, 2000 MAR p. 481.)

37.86.1502 HOME INFUSION THERAPY SERVICES, PROVIDER REQUIREMENTS (1) These requirements are in addition to those contained in rule provisions generally applicable to medicaid providers.

(2) Home infusion therapy service providers, as a condition of participation in the Montana medicaid program, must:

(a) maintain a current home infusion therapy agency license issued by the department's quality assurance division, or, if the provider is serving recipients outside the state of Montana, maintain a current license in the equivalent category under the laws of the state in which the services are provided; and

(b) enter into and maintain a current provider enrollment form under the provisions of ARM 37.85.402 with the department's fiscal agent to provide home infusion therapy services. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1996 MAR p. 2599, Eff. 10/4/96; TRANS, from SRS, 2000 MAR p. 481.)

Rules 03 and 04 reserved

37.86.1505 HOME INFUSION THERAPY SERVICES, REQUIREMENTS

(1) The requirements and restrictions in these rules apply for purposes of coverage and reimbursement of home infusion therapy services under the Montana medicaid program.

(2) Medicaid coverage and reimbursement of home infusion therapy services is available, subject to applicable requirements, for services provided to recipients that are residing in their own home, a nursing facility or any setting other than a hospital. Medicaid coverage and reimbursement of home infusion therapy services is not available to recipients who are receiving infusion therapy as a hospital inpatient or outpatient service.

(3) Except as otherwise provided by these rules, home infusion therapy services must be provided within the scope of practice permitted by applicable state law.

(4) For those services subject to prior authorization, the Montana medicaid program will not cover or reimburse home infusion therapy services unless the department or its designated agent has approved a prior authorization request. The department will determine the specific home infusion therapy services that require prior authorization in consultation with the department's drug use review board established pursuant to 42 USCA 1396r-8(g). A list of the specific services subject to prior authorization will be provided upon request made to the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(5) The Montana medicaid program will not cover or reimburse home infusion therapy services for the following:

(a) medications which can be appropriately administered orally, through intramuscular or subcutaneous injection, or through inhalation; and

(b) drug products that are not FDA approved or whose use in the non-hospital setting presents an unreasonable health risk to the patient.

(6) The department will determine the specific therapies that are not allowable as home infusion therapy services under (5)(a) or (b) in consultation with the department's drug use review board established pursuant to 42 USCA 1396r-8(g). A list of the specific therapies determined not allowable under this rule will be provided upon request made to the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1996 MAR p. 2599, Eff. 10/4/96; TRANS, from SRS, 2000 MAR p. 481.)

37.86.1506 HOME INFUSION THERAPY SERVICES, REIMBURSEMENT

(1) Subject to the requirements of these rules, the Montana medicaid program will pay for home infusion therapy services on a fee basis, as specified in the department's home infusion therapy services fee schedule. The department adopts and incorporates by reference the home infusion therapy services fee schedule dated April 2004. A copy of the home infusion therapy services fee schedule may be obtained from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951. The specified fees are on a per day or a per dose basis as specified in the fee schedule. The fees are bundled fees which cover all home infusion therapy services as defined in ARM 37.86.1501.

(2) For home infusion therapy services also reimbursed for the recipient by the medicare program, medicare payments will be considered to be third party payments and, if the medicare payment is less than the medicaid fee schedule amount, medicaid will pay the difference between the medicare payment and the medicaid fee specified in the home infusion therapy fee schedule described in (1).

(3) Covered drugs prepared and administered as part of a recipient's home infusion therapy program are separately billable under the Montana medicaid outpatient drug program as specified in ARM 37.86.1102 and 37.86.1105.

(4) Subject to (4)(c), professional nursing services provided as part of a recipient's home infusion therapy program are separately billable and will be reimbursed in the following manner:

(a) nursing services provided by a home health agency will be reimbursed under the home health services program as provided in ARM 37.40.701, 37.40.702 and 37.40.705;

(b) nursing services provided by licensed nurses employed by the home infusion therapy agency will be reimbursed to the agency under the methodology specified in ARM 37.86.2207; and

(c) professional nursing services are not separately billable when the home infusion therapy program is provided in a nursing facility. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 1996 MAR p. 2599, Eff. 10/4/96; TRANS, from SRS, 2000 MAR p. 481; AMD, 2003 MAR p. 1314, Eff. 7/1/03; AMD, 2004 MAR p. 750, Eff. 4/9/04.)

Subchapter 16 reserved

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Subchapter 17

Family Planning Services

37.86.1701 FAMILY PLANNING SERVICES (1) Family planning services may be provided by a physician in accordance with ARM 37.86.101 through 37.86.105, a nurse-practitioner in accordance with ARM 37.86.201 through 37.86.205 or a local delegate agency of the family planning program of the department of public health and human services. Family planning services provided by a local delegate agency may include:

(a) annual visit;
(b) comprehensive history;
(c) initial physical examination;
(d) initial visit;
(e) laboratory services;
(f) medical counseling; and
(g) routine visit.

(2) "Annual visit" means a return visit at least once per year, following the initial visit, for a physical examination, laboratory services, and health history. The physical will include all examinations and services required for the initial physical. The laboratory services may include a urinalysis, hematocrit, and PAP test.

(3) "Comprehensive history" means a complete history of obstetrical/gynecological conditions, significant illnesses, disease, hospitalization, problems relating to previous contraceptive use, and relevant family health, psychiatric or social information which is recorded and maintained in the recipient's medical record.

(4) "Contraceptive supplies" means FDA approved intrauterine devices (IUD), spermicidals, barrier methods, implants and oral contraceptives.

(5) "Local delegate agency" means a clinic receiving funding through the department under Title X, the Family Planning Services and Population Research Act of 1970, under the Public Health Services Act, 42 U.S.C. 300 et seq.

(6) "Initial physical examination" means an examination that may include the following procedures conducted at the initial visit of the recipient:

(a) thyroid palpation;
(b) inspection and palpation of breasts and axillary glands, with instruction to the recipient for self-examination;
(c) auscultation of heart and lungs;

(d) blood pressure;
(e) weight and height;
(f) abdominal examination;

(g) pelvic, including speculum, bimanual and recto vaginal examination;

(h) insertion, fitting or removal of an IUD or diaphragm; and

(i) implantation or removal of subcutaneous contraceptives.

(7) "Initial visit" means the first contact of the recipient and may include:

(a) initial comprehensive review of medical history;

(b) physical examination;

(c) information and education regarding contraceptive methods;

(d) ordering of laboratory services;

(e) prescription for contraceptive supplies;

(f) post examination interview;

(g) any counseling rendered the day of the visit;

(h) insertion fitting or removal of an IUD or diaphragm; and

(i) implantation or removal of subcutaneous contraceptives.

(8) "Laboratory services" means the delegate agency ordered tests with specimen collection carried out by the provider.

(9) "Medical counseling" means counseling services provided by a physician, mid-level practitioner, or other medical professional under the supervision of the clinic's medical director regarding:

(a) pre-conceptual problems;

(b) problem pregnancies;

(c) HIV sexuality issues;

(d) sexually transmitted diseases;

(e) abnormal pap smears;

(f) sexuality and the developmentally disabled client; and

(g) sterilization.

(10) "Routine visit" means a visit to provide contraceptive follow-up and monitoring and to correct any problems associated with utilization of medical services including treatment for vaginal infections. Medical revisit may be used for a return visit for a diaphragm, IUD or subcutaneous device and includes the insertion, fitting, implantation or removal of the device. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-141, MCA; NEW, Eff. 11/4/74; AMD, 1986 MAR p. 970, Eff. 5/30/86; AMD, 1990 MAR p. 2302, Eff. 12/28/90; AMD, 1991 MAR p. 1037, Eff. 7/1/91; AMD, 1994 MAR p. 313, Eff. 2/11/94; TRANS, from SRS, 2000 MAR p. 481.)

Rules 02 through 04 reserved

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37.86.1705 FAMILY PLANNING SERVICES, REQUIREMENTS These requirements are in addition to those contained in ARM 37.85.401, 37.85.406, 37.85.407, 37.85.410 and 37.85.414.

(1) Contraceptive clinic services are the services of a physician or the services of the local delegate agencies of the family planning program of the department of public health and human services.

(2) Laboratory services must be ordered by a physician.

(3) Contraceptive supplies must be prescribed by a physician.

(4) Eligible recipients requesting family planning services must be free from coercion or mental pressure and free to choose the method of family planning to be used. (History: Sec. 53-6-113, MCA; IMP, 53-6-101 and 53-6-141, MCA; NEW, 1986 MAR p. 970, Eff. 5/30/86; TRANS, from SRS, 2000 MAR p. 481.)

37.86.1706 FAMILY PLANNING SERVICES, REIMBURSEMENT

(1) Reimbursement for family planning services is as follows:

(a) for physicians reimbursement is provided in accordance with the methodologies described in ARM 37.85.212 and 37.86.105;

(b) for mid-level practitioners reimbursement is provided in accordance with the methodologies described in ARM 37.86.205 and 37.86.212;

(c) for local delegate agencies the lowest of the provider's usual and customary charge for this service or the department's fee schedule.

(2) The fees in the department's fee schedule for the local delegate agencies are for each item or procedure the average of the charges for that item or procedure submitted by the delegate agencies during the preceding fiscal year. The adjustments to the fee schedule based upon the annual averaging may not exceed the adjustment for family planning services authorized by the legislature for that fiscal year. The fees in the fee schedule for services provided by physicians or mid-level practitioners may not exceed the fees available for those services set forth in ARM 37.86.105 or 37.86.205 and 37.86.212.

(3) The procedure billing codes and department fee schedules are available from the department's fiscal agent. (History: Sec. 53-6-113, MCA; IMP, 53-6-101 and 53-6-141, MCA; NEW, 1986 MAR p. 970, Eff. 5/30/86; AMD, 1990 MAR p. 2302, Eff. 12/28/90; AMD, 1991 MAR p. 1037, Eff. 7/1/91; AMD, 1994 MAR p. 313, Eff. 2/11/94; AMD, 1998 MAR p. 676, Eff. 3/13/98; TRANS, from SRS, 2000 MAR p. 481; AMD, 2001 MAR p. 1476, Eff. 8/10/01; AMD, 2001 MAR p. 2156, Eff. 10/26/01.)

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Subchapter 18

Prosthetic Devices, Durable Medical Equipment and Medical Supplies

37.86.1801 PROSTHETIC DEVICES, DURABLE MEDICAL EQUIPMENT, AND MEDICAL SUPPLIES, DEFINITIONS (1) "Prosthetic devices" means replacement, corrective, or supportive devices or appliances which artificially replace a missing portion of the body to:

(a) prevent or correct physical deformity or malfunction; or

(b) support a weak or deformed portion of the body.

(2) "Durable medical equipment" means the most economical and medically necessary equipment appropriate for use in a patient's home or residence, including, but not limited to, wheelchairs, walkers, canes, crutches, hospital beds, oxygen equipment and sickroom equipment.

(3) "Medical supplies" means disposable or non-reusable medical supplies, including, but not limited to, splints, bandages and oxygen.

(4) "Prior authorization" means the medicaid program's review and approval of an item's medical necessity and coverage by medicaid prior to the delivery of the item. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-141, MCA; NEW, Eff. 11/4/74; AMD, 1981 MAR p. 559, Eff. 6/12/81; AMD, 1981 MAR p. 1977, Eff. 1/1/82; AMD, 1986 MAR p. 1911, Eff. 1/1/87; AMD, 1992 MAR p. 1872, Eff. 8/28/92; TRANS, from SRS, 2000 MAR p. 481.)

37.86.1802 PROSTHETIC DEVICES, DURABLE MEDICAL EQUIPMENT, AND MEDICAL SUPPLIES, GENERAL REQUIREMENTS (1) These requirements are in addition to those contained in rule provisions generally applicable to medicaid providers. Requirements for prosthetic devices, durable medical equipment, and medical supplies utilized by nursing facility residents are contained in the department's rules governing nursing facility reimbursement.

(2) Reimbursement for prosthetic devices, durable medical equipment and medical supplies shall be limited to items delivered in the most appropriate and cost effective manner. The items must be medically necessary and prescribed in writing prior to delivery by a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by state law.

(a) The prescription must indicate the diagnosis, the medical necessity, and projected length of need for prosthetic devices, durable medical equipment and medical supplies. The original prescription must be retained in accordance with the requirements of ARM 37.85.414. Prescriptions for medical supplies used on a continuous basis shall be renewed by a physician at least every 12 months and must specify the monthly quantity of the supply.

(i) Prescriptions for oxygen shall include the liter flow per minute, the hours of use per day and the recipient's PO2 or oxygen saturation blood test(s) results.

(b) Subject to the provisions of (3), medical necessity for oxygen is determined in accordance with the medicare criteria set forth in the Medicare Durable Medical Equipment Regional Carrier (DMERC) Region D Supplier Manual, Coverage Issue 60-4, Use of Home Oxygen, pages X-5 through X-9, (December 1, 1997), which is adopted and incorporated by reference. The medicare criteria specify the health conditions and levels of hypoxemia in terms of blood gas values for which oxygen will be considered medically necessary. The medicare criteria also specify the medical documentation and laboratory evidence required to support medical necessity. A copy of the medicare criteria may be obtained from the Department of Public Health and Human Services, Child and Adult Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(c) Reimbursement for oxygen is made on a monthly basis. Only one unit may be billed per month regardless of the actual amount used by the patient.

(d) A statement of medical necessity for the rental of durable medical equipment, excluding oxygen equipment, shall indicate the length of time the equipment will be needed. All prescriptions shall be signed and dated.

(e) No more than one month's medical supplies may be provided to a medicaid recipient based on the physician's orders.

(f) A determination of the medical necessity of an item made by the medicare program is applicable to the medicaid program.

(g) Recipients shall be limited to a new wheelchair no more than once every five years, unless the department determines that a new chair is required sooner because the recipient's current chair is causing the recipient serious health problems or because of a significant change in the recipient's medical condition.

(3) Providers of oxygen to recipients for whom oxygen was determined to be medically necessary prior to the adoption of the medicare criteria, effective March 1, 1998, set forth in (2) may be reimbursed for oxygen services to those recipients, even though the oxygen would not be medically necessary for them under the medicare criteria, until the recipient's next recertification of medical necessity.

(4) The following items are not reimbursable by the program:

(a) items determined not to be medically necessary by the medicare program, except as provided in (3);

(b) orthopedic shoes, corrections, and shoe repairs unless the criteria in (4)(b)(i) or (ii) are met and the physician's prescription indicates that:

(i) the shoes are attached to a brace or orthotic device which cannot be accommodated in a regular shoe; or

(ii) the shoes are covered under medicare criteria for therapeutic shoes for diabetics. The department adopts and incorporates by reference the Durable Medical Equipment Regional Carrier (DMERC) Region D supplier manual for coverage of therapeutic shoes for diabetics (March 1998). This manual describes the conditions under which the medicare program will cover therapeutic shoes for diabetics. A copy of the medicare criteria is available upon request from the Department of Public Health and Human Services, Child and Adult Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951;

(c) convenience and comfort items;

(d) payment for provider's travel;

(e) nutrient solutions except when they are for parenteral and enteral nutrition therapy, are the primary source of nutrition for patients, and are medically appropriate;

(f) purchase of air fluidized beds;

(g) any delivery, mailing or shipping fees or other costs of transporting the item to the recipient's location;

(h) disposable incontinence wipes;

(i) adaptive equipment;
(j) building modifications;
(k) automobile modifications;
(l) environmental control devices;
(m) exercise equipment;
(n) personal care items;
(o) alarms;
(p) educational equipment;
(q) personal computers; and
(r) sexual aids or devices.

(5) The date of service for custom molded or fitted items is the date upon which the provider completes the mold or fitting and either orders the equipment from another party or makes an irrevocable commitment to the production of the item. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-113 and 53-6-141, MCA; NEW, 1981 MAR p. 1977, Eff. 1/1/82; AMD, 1986 MAR p. 1911, Eff. 1/1/87; AMD, 1989 MAR p. 282, Eff. 2/10/89; AMD, 1990 MAR p. 1951, Eff. 11/1/90; AMD, 1991 MAR p. 1030, Eff. 7/1/91; AMD, 1992 MAR p. 1872, Eff. 8/28/92; AMD, 1994 MAR p. 2546, Eff. 9/9/94; AMD, 1998 MAR p. 497, Eff. 2/13/98; AMD, 1998 MAR p. 2168, Eff. 8/14/98; TRANS, from SRS, 2000 MAR p. 481; AMD, 2001 MAR p. 986, Eff. 6/8/01; AMD, 2003 MAR p. 1314, Eff. 7/1/03; AMD, 2004 MAR p. 82, Eff. 1/1/04.)

Rules 03 through 05 reserved

37.86.1806 PROSTHETIC DEVICES, DURABLE MEDICAL EQUIPMENT, AND MEDICAL SUPPLIES, REIMBURSEMENT REQUIREMENTS

(1) Requirements for the purchase or rental of prosthetic devices, durable medical equipment, medical supplies and related maintenance, repair and services are as follows:

(a) Subject to the requirements of this rule, the department will pay the lowest of the following for prosthetic devices, durable medical equipment, medical supplies and related maintenance, repair and services:

(i) the provider's usual and customary charge for the item; or

(ii) the department's fee schedule maintained in accordance with the methodology described in ARM 37.86.1807.

(b) For all purposes under ARM 37.86.1806 and 37.86.1807, the amount of the provider's usual and customary charge may not exceed the reasonable charge usually and customarily charged by the provider to all payers. The charge will be considered reasonable if less than or equal to the manufacturer's suggested list price. For items without a manufacturer's suggested list price, the charge will be considered reasonable if the provider's acquisition cost from the manufacturer is at least 50% of the charge amount. For items that are custom fabricated at the place of service, the amount charged will be considered reasonable if it does not exceed the average charge of all medicaid providers by more than 20%. For rental items, the reasonable monthly charge may not exceed a percentage of the reasonable purchase charge, as specified in (3).

(c) A prior authorization is required for the following:

(i) for any line item of prosthetic device, durable medical equipment, medical supplies and related maintenance, repair and services on which the department's fee is equal to or greater than $1,000; and

(ii) all items identified as requiring prior authorization in the department's fee schedule referenced in ARM 37.86.1807(2).

(d) Prior authorization of a claim does not guarantee payment for the requested item or service.

(e) Reimbursement for prosthetic devices, durable medical equipment, medical supplies and related maintenance, repair and services utilized by nursing facility residents and billed by a nursing facility is subject to the limits in the department's rules governing nursing facility reimbursement.

(2) For items that require prior authorization, the authorization number must be included on the submitted claim.

(3) Medicaid reimbursement for items provided on a rental basis is limited as follows:

(a) Total medicaid rental reimbursement for items listed in medicare's capped rental program or classified by medicare as routine and inexpensive rental will be limited to 120% of the purchase price for that item. Monthly rental fees will be limited to 10% of the purchase price and payments will be limited to 12 months.

(i) For purposes of this limit, the purchase price is the purchase fee specified in the department's fee schedule established under ARM 37.86.1807.

(ii) Interruptions in the rental period of less than 60 days will not result in the start of a new 12-month period or new 120% of purchase price limit, but periods in which service is interrupted will not count toward the 12-month limit.

(iii) A change in supplier during the 12-month period will not result in the start of a new 12-month period or new 120% of purchase price limit. Providers are responsible to investigate whether another supplier has been providing the item to the recipient and medicaid will not notify suppliers of this information. The provider may rely upon a separate written statement of the recipient that another supplier has not been providing the item, unless the provider has knowledge of other facts or information indicating that another supplier has been providing the item. The supplier providing the item in the twelfth month of the rental period is responsible to transfer ownership to the recipient.

(iv) If rental equipment is changed to different but similar equipment, the change will not result in the start of a new 12-month period or new 120% of purchase price limit, unless:

(A) the change in equipment is medically necessary as a result of a substantial change in the recipient's medical condition;

(B) a new certification of medical necessity for the new equipment is completed and signed by a physician; and

(C) the medicaid services bureau prior authorizes the change in equipment.

(b) During the 12-month rental period, medicaid rental reimbursement includes all supplies, maintenance, repair, components, adjustments and services related to the item during the rental month. No additional amounts related to the item may be billed or reimbursed for the item during the 12-month rental period. The supplier providing the rental equipment during the rental period is responsible for all maintenance and servicing of the equipment.

(c) After 12 months rental, the recipient will be deemed to own the item and the provider must transfer ownership of the item to the recipient. After the 12-month rental period, the provider may bill separately for supplies, maintenance, repair, components, adjustments and services related to the item, subject to the requirements of these rules, except that repair charges are not reimbursable during the manufacturer's warranty period.

(d) All rentals will be paid on a monthly basis, except air fluidized beds which will be reimbursed at a daily rental rate.

(i) Medicaid will pay an entire monthly rental fee for the initial month of rental even if less than a full month. When a rental extends into a second or subsequent month, medicaid will pay a rental fee for a partial month only if the partial month period is at least 15 days.

(e) Items classified by medicare as needing frequent and substantial servicing will be reimbursed by medicaid on a monthly rental basis only. The 120% cap specified in (3)(a) does not apply and rental reimbursement may continue as long as the item is medically necessary.

(f) If the purchase of a rental item is cost effective, the department may negotiate with the provider to purchase the item.

(4) If no purchase fee has been set for a purchase item but a monthly rental fee has been set, medicaid reimbursement for purchased items shall be limited to 10 times the monthly rental fee established in accordance with ARM 37.86.1807.

(5) The department may contract with providers of prosthetic devices, durable medical equipment and medical supplies to be sole providers of a specific item in a geographic area.

(6) Medical coverage of diapers is limited to 180 diapers per recipient per month. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-141, MCA; NEW, 1981 MAR p. 1977, Eff. 1/1/82; AMD, 1982 MAR p. 1289, Eff. 7/1/82; AMD, 1986 MAR p. 1911, Eff. 1/1/87; AMD, 1989 MAR p. 282, Eff. 2/10/89; AMD, 1989 MAR p. 859, Eff. 6/30/89; AMD, 1991 MAR p. 1030, Eff. 7/1/91; AMD, 1992 MAR p. 1872, Eff. 8/28/92; AMD, 1994 MAR p. 2546, Eff. 9/9/94; AMD, 1995 MAR p. 1970, Eff. 10/1/95; TRANS, from SRS, 2000 MAR p. 481; AMD, 2001 MAR p. 986, Eff. 6/8/01; AMD, 2001 MAR p. 1476, Eff. 8/10/01; AMD, 2001 MAR p. 2156, Eff. 10/26/01; EMERG, AMD, 2003 MAR p. 999, Eff. 5/9/03; AMD, 2004 MAR p. 82, Eff. 1/1/04.)

37.86.1807 PROSTHETIC DEVICES, DURABLE MEDICAL EQUIPMENT, AND MEDICAL SUPPLIES, FEE SCHEDULE (1) Providers must bill for prosthetic devices, durable medical equipment, medical supplies and related maintenance, repair and services using the procedure codes and modifiers set forth and according to the definitions contained in the centers for medicare and medicaid services' (CMS) healthcare common procedure coding system (HCPCS). Information regarding billing codes, modifiers and HCPCS is available upon request from the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(2) Prosthetic devices, durable medical equipment and medical supplies shall be reimbursed in accordance with the department's fee schedule dated January 2005, which is adopted and incorporated by reference. A copy of the department's fee schedule may be obtained from the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(3) The department's fee schedule, referred to in ARM 37.86.1806(1), for items other than wheelchairs and items billed under generic or miscellaneous codes as described in (1), shall include fees set and maintained according to the following methodology:

(a) 100% of the medicare region D allowable fee;

(b) Except as provided in (4), for all items for which no medicare allowable fee is available, the department's fee schedule amount shall be 75% of the provider's usual and customary charge, until a reasonable fee is established through a pricing cluster as described in (3)(b)(ii).

(i) For purposes of (3)(b) and (4), the amount of the provider's usual and customary charge may not exceed the reasonable charge usually and customarily charged by the provider to all payers.

(A) The charge will be considered reasonable if less than or equal to the manufacturer's suggested list price.

(B) For items without a manufacturer's suggested list price, the charge will be considered reasonable if the provider's acquisition cost from the manufacturer is at least 50% of the charge amount.

(C) For items that are custom fabricated at the place of service, the amount charged will be considered reasonable if it does not exceed the average charge of all medicaid providers by more than 20%.

(D) For rental items, the reasonable monthly charge may not exceed a percentage of the reasonable purchase charge, as specified in ARM 37.86.1806(3).

(ii) For the purposes of (3)(b), a pricing cluster consists of product retail price lists from manufacturers and distributors. Such pricing is used to compare all provider billed charges for an item/service billed under a specific procedure code. The average charge from a 12-month period is considered reasonable if equal to or less than the average retail price of the pricing cluster. If the average charge is considered reasonable, a permanent fee will be set at 75% of the reasonable charge.

(iii) Items having no product retail list price, such as items customized by the provider, will be reimbursed at 75% of the provider's usual and customary charge as defined in (3)(b)(i).

(4) The department's fee schedule, referred to in ARM 37.86.1806(1), for all wheelchairs and items billed under generic or miscellaneous codes as described in (1) shall be 75% of the provider's usual and customary charge as defined in (3)(b)(i). (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-141, MCA; NEW, 1981 MAR p. 1977, Eff. 1/1/82; AMD, 1982 MAR p. 1289, Eff. 7/1/82; AMD, 1986 MAR p. 1911, Eff. 1/1/87; AMD, 1990 MAR p. 1951, Eff. 11/1/90; AMD, 1991 MAR p. 1030, Eff. 7/1/91; AMD, 1993 MAR p. 1112, Eff. 7/1/93; AMD, 1994 MAR p. 2546, Eff. 9/9/94; AMD, 1995 MAR p. 1970, Eff. 10/1/95; AMD, 1998 MAR p. 497, Eff. 2/13/98; AMD, 1998 MAR p. 2168, Eff. 8/14/98; AMD, 1999 MAR p. 1379, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 1664, Eff. 6/30/00; AMD, 2001 MAR p. 604, Eff. 4/27/01; AMD, 2001 MAR p. 986, Eff. 6/8/01; AMD, 2001 MAR p. 1476, Eff. 8/10/01; AMD, 2001 MAR p. 2156, Eff. 10/26/01; AMD, 2002 MAR p. 1779, Eff. 6/28/02; EMERG, AMD, 2002 MAR p. 2665, Eff. 9/27/02; EMERG, AMD, 2003 MAR p. 999, Eff. 5/9/03; AMD, 2003 MAR p. 1314, Eff. 7/1/03; AMD, 2004 MAR p. 82, Eff. 1/1/04; AMD, 2005 MAR p. 385, Eff. 3/18/05.)

Subchapter 19 reserved

Subchapter 20

Optometric Services

37.86.2001 OPTOMETRIC SERVICES, DEFINITIONS

(1) "Optometric services" means services provided by a licensed optometrist that are within the scope of practice. Optometric services include visual training. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-141, MCA; NEW, 1980 MAR p. 1758, Eff. 6/27/80; AMD, 1989 MAR p. 272, Eff. 3/1/89; AMD, 1997 MAR p. 1269, Eff. 7/22/97; TRANS, from SRS, 2000 MAR p. 481.)

37.86.2002 OPTOMETRIC SERVICES, REQUIREMENTS (1) These requirements are in addition to the rule provisions generally applicable to medicaid providers.

(2) The department hereby adopts and incorporates by reference the definitions found in the introduction of Physicians Current Procedural Terminology, fourth edition (CPT 4), published by the American medical association of Chicago, Illinois. These materials set forth meanings of terms commonly used by the Montana medicaid program in implementation of the program's optometric schedule. A copy of the definitions herein incorporated may be obtained through the Department of Public Health and Human Services, Health Policy and Services Division, P.O. Box 202951, 1400 Broadway, Helena, MT 59620-2951. Providers must bill for services using the procedure codes, and modifiers set forth, and according to the definitions contained in the health care financing administration's common procedure coding system (HCPCS). Information regarding billing codes, modifiers and HCPCS is available upon request from the Health Policy and Services Division at the address stated above.

(3) A medicaid recipient age 21 and over is limited to one eye examination for determination of refractive state per 730 day period unless one of the following circumstances exist:

(a) following cataract surgery more than one examination during the 730 day period is necessary; or

(b) the provider determines by screening that a loss of one line acuity has occurred with present glasses.

(4) A medicaid recipient under age 21 is limited to one eye examination for determination of refractive state per 365 day period unless one of the following circumstances exist:

(a) following cataract surgery, more than one examination during the 365 day period is necessary; or

(b) the provider determines by screening that a loss of one line acuity has occurred with present glasses. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-141, MCA; NEW, 1980 MAR p. 1758, Eff. 6/27/80; AMD, 1987 MAR p. 895, Eff. 7/1/87; AMD, 1988 MAR p. 758, Eff. 4/15/88; AMD, 1989 MAR p. 272, Eff. 3/1/89; AMD, 1997 MAR p. 1269, Eff. 7/22/97; TRANS, from SRS, 2000 MAR p. 481.)

Rules 03 and 04 reserved

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37.86.2005 OPTOMETRIC SERVICES, REIMBURSEMENT

(1) Subject to the requirements of this rule, the Montana medicaid program pays the following for optometric services:

(a) For patients who are eligible for medicaid, the lower of:

(i) the provider's usual and customary charge for the service; or

(ii) the reimbursement provided in accordance with the methodologies described in ARM 37.85.212. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-113 and 53-6-141, MCA; NEW, 1980 MAR p. 1612, Eff. 6/13/80; AMD, 1981 MAR p. 559, Eff. 6/12/81; AMD, 1981 MAR p. 1975, Eff. 1/1/82; AMD, 1982 MAR p. 1289, Eff. 7/1/82; AMD, 1987 MAR p. 895, Eff. 7/1/87; AMD, 1988 MAR p. 758, Eff. 4/15/88; AMD, 1989 MAR p. 272, Eff. 3/1/89; AMD, 1989 MAR p. 859, Eff. 6/30/89; AMD, 1990 MAR p. 1479, Eff. 7/27/90; AMD, 1997 MAR p. 1269, Eff. 7/22/97; AMD, 1998 MAR p. 676, Eff. 3/13/98; TRANS, from SRS, 2000 MAR p. 481; AMD, 2001 MAR p. 1476, Eff. 8/10/01; AMD, 2001 MAR p. 2156, Eff. 10/26/01.)

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Subchapter 21

Eyeglass Services

37.86.2101 EYEGLASSES, DEFINITIONS (1) Eyeglasses mean corrective lens and/or frames prescribed by an ophthalmologist or by an optometrist, to aid and improve vision.

(a) Corrective lenses also include contact lenses. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-141, MCA; NEW, 1980 MAR p. 1759, Eff. 6/27/80; AMD, 1989 MAR p. 272, Eff. 3/1/89; AMD, 1997 MAR p. 1269, Eff. 7/22/97; TRANS, from SRS, 2000 MAR p. 481.)

37.86.2102 EYEGLASSES, SERVICES, REQUIREMENTS AND RESTRICTIONS (1) These requirements are in addition to the rule provisions generally applicable to medicaid providers.

(2) The dispensing service may be provided by an ophthalmologist, an optometrist, an optician, or their employees within the scope of their professional practice allowed by law.

(3) Ophthalmologists, optometrists, opticians or their employees dispensing eyeglasses and ophthalmologists or optometrists or their employees dispensing contact lenses must bill for services using the procedure codes and modifiers set forth, and according to the definitions contained, in the health care financing administration's common procedure coding system (HCPCS). Information regarding billing codes, modifiers and HCPCS is available upon request from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(4) A recipient under 21 years of age is limited to one pair of eyeglasses per 365 day period and each recipient 21 years of age or older is limited to one pair of eyeglasses every 730 day period unless additional pairs are necessary due to any of the following circumstances:

(a) cataract surgery;

(b) .50 diopter change in correction in sphere;

(c) .75 diopter change in cylinder;

(d) .5 prism diopter change in vertical prism;

(e) .50 diopter change in the near reading power;

(f) a minimum of a 5 degree change in axis of any cylinder less than or equal to 3.00 diopters;

(g) a minimum of a 3 degree change in axis of any cylinder greater than 3.00 diopters;

(h) any 1 prism diopter or more change in lateral prism; or

(i) the inability of the recipient to wear bifocals because of a diagnosed medical condition.

(i) When this is the case, the recipient may be allowed two pairs of single vision eyeglasses every 730 day period if he is 21 years of age or over, or every 365 day period if he is under 21 years of age.

(5) A recipient may obtain replacement lenses only 365 days after the existing eyeglasses were dispensed if the lenses are unusable.

(6) Contact lenses may be provided only if medically necessary.

(a) The limits stated in (4) and (5) apply to contacts.

(b) The dispensing provider must receive prior authorization from the department for contact lenses and dispensing fee. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-141, MCA; NEW, 1980 MAR p. 1759, Eff. 6/27/80; AMD, 1987 MAR p. 895, Eff. 7/1/87; AMD, 1988 MAR p. 758, Eff. 4/15/88; AMD, 1989 MAR p. 272, Eff. 3/1/89; AMD, 1997 MAR p. 1269, Eff. 7/22/97; AMD, 1998 MAR p. 676, Eff. 3/13/98; TRANS, from SRS, 2000 MAR p. 481.)

Rules 03 and 04 reserved

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37.86.2105 EYEGLASSES, REIMBURSEMENT (1) Eyeglasses are paid by the department through a single volume purchase contract.

(2) Reimbursement for contact lenses or dispensing fees is as follows:

(a) The department pays the lower of the following:

(i) the provider's usual and customary charge for the service; or

(ii) the amount specified for the particular service or item in the department's fee schedule.

(3) The department hereby adopts and incorporates by reference the department's fee schedule dated December 2004 which sets forth the reimbursement rates for eyeglasses, dispensing services and other related supplies for optometric services. A copy of the department's fee schedule may be obtained from the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-113 and 53-6-141, MCA; NEW, 1980 MAR p. 1611, Eff. 6/13/80; AMD, 1981 MAR p. 559, Eff. 6/12/81; AMD, 1981 MAR p. 1975, Eff. 1/1/82; AMD, 1982 MAR p. 1289, Eff. 7/1/82; AMD, 1989 MAR p. 272, Eff. 3/1/89; AMD, 1989 MAR p. 859, Eff. 6/30/89; AMD, 1990 MAR p. 1479, Eff. 7/27/90; AMD, 1997 MAR p. 1269, Eff. 7/22/97; AMD, 1998 MAR p. 676, Eff. 3/13/98; AMD, 1999 MAR p. 1379, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 1664, Eff. 6/30/00; AMD, 2001 MAR p. 1117, Eff. 6/22/01; AMD, 2002 MAR p. 1779, Eff. 6/28/02; AMD, 2002 MAR p. 3329, Eff. 11/28/02; AMD, 2005 MAR p. 265, Eff. 2/11/05.)

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Subchapter 22

Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT)

37.86.2201 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT), PURPOSE, ELIGIBILITY AND SCOPE

(1) The early and periodic screening, diagnostic and treatment services (EPSDT) are preventive health screenings, diagnostic services, and medically necessary treatment services as specified in these rules.

(2) Services provided for EPSDT purposes are only available to medicaid eligible persons up to and including 20 years of age.

(3) Limitations on the amount, scope or duration for particular services, funded with medicaid monies, do not apply to such services when provided to EPSDT recipients unless otherwise provided in these rules.

(4) Criteria, requirements and limitations applicable to eligibility for and the receipt of home and community services provided under a medicaid waiver, govern the provision of waiver and EPSDT services to persons who are eligible for both EPSDT and waiver services.

(5) Criteria, requirements and limitations generally applicable to medicaid services, recipients or providers, including but not limited to medical necessity requirements, experimental or cosmetic service exclusions, prior authorization, prescreening, certification or utilization review requirements, provider participation, billing or reimbursement requirements, recipient eligibility or copayment requirements, or other similar requirements or restrictions apply to EPSDT recipients, EPSDT services and providers of services to EPSDT recipients.

(6) An EPSDT service may only be provided by a provider that is appropriate and qualified to deliver the service in accordance with the relevant and applicable educational, professional and licensing standards and requirements.

(7) An EPSDT service must be delivered in accordance with those standards and requirements applicable to the provision of the service.

(8) School based health related services may only be provided in public school districts, full-service education cooperatives and joint boards described in ARM 37.86.2231.

(9) A service, item or provider category is not available as an EPSDT service unless made available in accordance with these rules. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1980 MAR p. 1790, Eff. 6/27/80; AMD, 1987 MAR p. 205, Eff. 2/27/87; AMD, 1990 MAR p. 2299, Eff. 12/28/90; AMD, 1992 MAR p. 2788, Eff. 1/1/93; AMD, 1995 MAR p. 2501, Eff. 11/23/95; AMD, 1997 MAR p. 548, Eff. 3/25/97; AMD, 1998 MAR p. 3219, Eff. 12/4/98; AMD, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 481; AMD, 2003 MAR p. 1316, Eff. 6/27/03.)

Rules 02 through 04 reserved

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37.86.2205 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT), REQUIRED SCREENING AND PREVENTIVE SERVICES (1) EPSDT screening and preventive services are available in accordance with this rule.

(2) The number and timing of comprehensive health, vision, hearing and dental screenings must be as specified in the EPSDT provider manual.

(a) More frequent screening services than those specified in the EPSDT provider manual are covered when considered medically necessary to determine the existence of suspected physical or mental illnesses or conditions.

(3) Screening and preventive services must include assessments, exams, immunizations, tests, health education and other features as specified in the EPSDT provider manual.

(4) The department hereby adopts and incorporates herein by reference the department's provider manual updated through June 2000. The provider manual, issued by the department to all providers of EPSDT services, informs providers of the requirements applicable to the delivery of services. A copy of the department's EPSDT provider manual is available from the Department of Public Health and Human Services, Health Policy and Services Division, Medicaid Services Bureau, 1400 Broadway, P.O. Box 202951, Helena, MT, 59620-2951. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1980 MAR p. 1790, Eff. 6/27/80; AMD, 1987 MAR p. 205, Eff. 2/27/87; AMD, 1987 MAR p. 895, Eff. 7/1/87; AMD, 1990 MAR p. 2299, Eff. 12/28/90; AMD, 1992 MAR p. 1402, Eff. 7/1/92; AMD, 1992 MAR p. 2788, Eff. 1/1/93; AMD, 1995 MAR p. 2501, Eff. 11/23/95; AMD, 1998 MAR p. 3219, Eff. 12/4/98; AMD, 1999 MAR p. 1379, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 1664, Eff. 6/30/00.)

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37.86.2206 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT), MEDICAL AND OTHER SERVICES

(1) EPSDT eligible persons may receive any services otherwise available to persons eligible for medicaid funded services.

(2) In addition to the services generally available to medicaid recipients, the following services are available to EPSDT eligible persons:

(a) nutrition services as provided in ARM 37.86.2209;

(b) chiropractic services as provided in ARM 37.86.2211;

(c) outpatient chemical dependency treatment as provided in ARM 37.86.2213;

(d) private duty nursing as provided in ARM 37.86.2217;

(e) the therapeutic portion of medically necessary therapeutic youth group home treatment as provided in ARM 37.86.2219;

(f) the therapeutic portion of medically necessary therapeutic family care treatment as provided in ARM 37.86.2221; and

(g) school based health related services as provided in ARM 37.86.2230.

(3) Requests for prior authorization must be made in writing to the Department of Public Health and Human Services, Addictive and Mental Disorders Division, Mental Health Program, 555 Fuller Avenue, P.O. Box 202905, Helena, MT 59620-2905, or to the department's designee. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1980 MAR p. 1790, Eff. 6/27/80; AMD, 1987 MAR p. 205, Eff. 2/27/87; AMD, 1990 MAR p. 2299, Eff. 12/28/90; AMD, 1992 MAR p. 1402, Eff. 7/1/92; AMD, 1992 MAR p. 2788, Eff. 1/1/93; AMD, 1993 MAR p. 1540, Eff. 7/16/93; AMD, 1995 MAR p. 2501, Eff. 11/23/95; AMD, 1997 MAR p. 548, Eff. 3/25/97; AMD, 1998 MAR p. 3219, Eff. 12/4/98; AMD, 1999 MAR p. 1806, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 481; AMD, 2001 MAR p. 27, Eff. 1/12/01; AMD, 2003 MAR p. 1316, Eff. 6/27/03.)

NEXT PAGE IS 37-20307

37.86.2207 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT), REIMBURSEMENT (1) Reimbursement for an EPSDT service, except as otherwise provided in this rule, is the lowest of the following:

(a) the provider's usual and customary charge for the service;

(b) the reimbursement determined in accordance with the methodologies provided in ARM 37.85.212 and 37.86.105;

(c) the department's medicaid mental health fee schedule, except for the by report method; or

(d) for public agencies, cost based reimbursement as determined in accordance with OMB Circular A-87, Cost Principles for State, Local and Indian Tribal Governments as established and approved by the department. The department adopts and incorporates by reference the OMB Circular A-87, Cost Principles for State, Local and Indian Tribal Governments, as further amended August 29, 1997. A copy of OMB Circular A-87 may be obtained from the Department of Public Health and Human Services, Health Resources Division, Children's Mental Health Bureau, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(2) Reimbursement for outpatient chemical dependency treatment, nutrition, and private duty nursing services is specified in the department's EPSDT fee schedule. The department adopts and incorporates by reference the department's EPSDT fee schedule dated July 2003. A copy of the fee schedule may be obtained from the Department of Public Health and Human Services, Health Resources Division, Children's Mental Health Bureau, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(3) Reimbursement for the therapeutic portion of therapeutic youth group home treatment services is the lesser of:

(a) the amount specified in the department's medicaid mental health fee schedule. The department adopts and incorporates by reference the department's medicaid mental health and mental health services plan, individuals under 18 years of age, fee schedule dated July 15, 2005. A copy of the fee schedule may be obtained from the Department of Public Health and Human Services, Health Resources Division, Children's Mental Health Bureau, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951; or

(b) the provider's usual and customary charges (billed charges).

(4) Reimbursement for the therapeutic portion of therapeutic family care treatment services is the lesser of:

(a) the amount specified in the department's medicaid mental health fee schedule; or

(b) the provider's usual and customary charges (billed charges).

(5) For purposes of (3) and (4), "patient day" means a whole 24-hour period that a person is present and receiving therapeutic youth group home or therapeutic family care services. Even though a person may not be present for a whole 24-hour period, the day of admission is a patient day. The day of discharge is not a patient day.

(6) Reimbursement will be made to a provider for reserving a therapeutic youth group home or therapeutic youth family care (other than permanency therapeutic family care) bed while the recipient is temporarily absent only if:

(a) the recipient's plan of care documents the medical need for therapeutic home visits as part of a therapeutic plan to transition the recipient to a less restrictive level of care;

(b) the recipient is temporarily absent on a therapeutic home visit;

(c) the provider clearly documents staff contact and recipient achievements or regressions during and following the therapeutic home visit; and

(d) the recipient is absent from the provider's facility for no more than three patient days per absence.

(7) No more than 14 patient days per recipient in each rate year will be allowed for therapeutic home visits.

(8) A service for which a fee is not set in or determinable through the EPSDT provider manual, ARM 37.85.212 or 37.86.105 is reimbursed at a fee negotiated in advance of the provision of the service. A service provided before there is a negotiated fee is reimbursed at an amount determined by the department.

(9) Reimbursements for school based health related services are specified in the school based health service fee schedule dated September 1, 2005. Rates are 90% of the fees as specified in (1)(a) through (d), adjusted to reimburse these services at the federal matching assistance percentage (FMAP) rate.

(10) The department will not reimburse providers for two services that duplicate one another on the same day. The department adopts and incorporates by reference the matrix of services excluded from simultaneous reimbursement dated January 1, 2003. A copy of the MH (Mental Health) simultaneous Reimbursement Exclusions matrix is posted on the internet at the department's home page at www.dphhs.mt.gov/aboutus/divisions/addictivementaldisorders/services/index.shtml or may be obtained by writing the Department of Public Health and Human Services, Health Resources Division, Children's Mental Health Bureau, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(11) Information regarding current reimbursement or copies of fee schedules for EPSDT services may be obtained from the Department of Public Health and Human Services, Health Resources Division, Children's Mental Health Bureau, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951. (History: 53-2-201 and 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1992 MAR p. 2788, Eff. 1/1/93; AMD, 1993 MAR p. 1540, Eff. 7/16/93; AMD, 1995 MAR p. 2501, Eff. 11/23/95; AMD, 1997 MAR p. 548, Eff. 3/25/97; AMD, 1998 MAR p. 3219, Eff. 12/4/98; AMD, 1999 MAR p. 1806, Eff. 7/1/99; AMD, 1999 MAR p. 1379, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 1664, Eff. 6/30/00; AMD, 2001 MAR p. 27, Eff. 1/12/01; EMERG, AMD, 2001 MAR p. 989, Eff. 6/08/01; AMD, 2001 MAR p. 1476, Eff. 8/10/01; AMD, 2001 MAR p. 2041, Eff. 10/12/01; AMD, 2001 MAR p. 2156, Eff. 10/26/01; EMERG, AMD, 2002 MAR p. 1328, Eff. 4/26/02; AMD, 2002 MAR p. 1779, Eff. 6/28/02; EMERG, AMD, 2003 MAR p. 1316, Eff. 6/27/03; EMERG, AMD, 2003 MAR p. 1314, Eff. 7/1/03; AMD, 2004 MAR p. 83, Eff. 1/1/04; AMD, 2005 MAR p. 1787, Eff. 9/23/05.)

Rule 08 reserved

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37.86.2209 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT), NUTRITION SERVICES (1) Nutrition services may include:

(a) nutrition counseling for counseling directly with a child, or with a responsible care giver, to explain the nutrition assessment and to implement a plan of nutrition care;

(b) nutrition assessment for evaluation of a child's nutritional problems, and design of a plan to prevent, improve or resolve identified nutritional problems, based upon the health objectives, resources and capacity of the child;

(c) nutrition consultation for consultation with or for health professionals, researching or resolving special nutrition problems or referring a child to other services, pertaining to the nutritional needs of a child; or

(d) nutrition education for routine education for normal nutritional needs. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 2001 MAR p. 27, Eff. 1/12/01.)

Rule 10 reserved

37.86.2211 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT), CHIROPRACTIC SERVICES

(1) Chiropractic services are limited to evaluation and management office visits, manual manipulation of the spine, and x-rays to support the diagnosis of subluxation of the spine. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 2001 MAR p. 27, Eff. 1/12/01.)

Rule 12 reserved

37.86.2213 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT), OUTPATIENT CHEMICAL DEPENDENCY TREATMENT SERVICES (REPEALED) (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 2001 MAR p. 27, Eff. 1/12/01; REP, 2003 MAR p. 803, Eff. 4/25/03.)

Rules 14 through 16 reserved

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37.86.2217 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT), PRIVATE DUTY NURSING SERVICES

(1) Private duty nursing services include:

(a) skilled nursing services provided directly to a child; and

(b) patient-specific training provided to a registered nurse or licensed practical nurse when a child is new to the nursing agency, when a change in the condition of a child requires additional training for the current nurse, or when a change in nursing personnel requires a new nurse to be trained to care for a child.

(2) Private duty nursing services do not include:

(a) psychological or mental health counseling;

(b) nurse supervision services including chart review, case discussion or scheduling by a registered nurse; or

(c) travel time to and from the recipient's place of service.

(3) Private duty nursing services must be authorized prior to the provision of services and any time the plan of care is amended. Authorization must be renewed with the department or the department's designated review agent every 90 days during the first 6 months of services, and every 6 months thereafter.

(a) Authorization is based on approval of a plan of care by the department or department's designated review agent.

(b) A provider of private duty nursing services must be an incorporated entity meeting the legal criteria for independent contractor status that either employs or contracts with nurses for the provision of nursing services. The department does not contract with or reimburse individual nurses as providers of private duty nursing services. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 2001 MAR p. 27, Eff. 1/12/01.)

Rule 18 reserved

37.86.2219 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT), THERAPEUTIC YOUTH GROUP HOME SERVICES (1) The therapeutic portion of medically necessary therapeutic youth group home treatment is covered if the treatment is ordered by a licensed physician, licensed psychologist, masters level licensed clinical social worker (MSW) or a licensed professional counselor (LPC), and prior-authorized by the department or its designee according to the provisions of ARM 37.88.101.

(a) The therapeutic portion of intensive level therapeutic youth group home treatment, as defined in ARM Title 37, chapters 37 and 97, is covered if provided by a therapeutic youth group home licensed by and contracted with the department to provide intensive level therapeutic youth group home services.

(b) The therapeutic portion of campus based therapeutic youth group home treatment, as defined in ARM Title 37, chapters 37 and 97, is covered if provided by a therapeutic youth group home licensed by and contracted with the department to provide campus based therapeutic youth group home services.

(c) The therapeutic portion of moderate level therapeutic youth group home treatment, as defined in ARM Title 37, chapters 37 and 97, is covered if provided by a therapeutic youth group home licensed by and contracted with the department to provide moderate level therapeutic youth group home services.

(d) Medicaid will not reimburse for room, board, maintenance or any other non-therapeutic component of youth group home treatment.

(e) If the therapeutic youth group home provider's facility is not located within the state of Montana, the provider must maintain a current license in the equivalent category under the laws of the state in which the facility is located.

(2) Medicaid reimbursement is not available for therapeutic youth group home services unless the provider submits to the department or its designee in accordance with these rules a complete and accurate certificate of need that certifies the necessary level of care for recipients who have a serious emotional disturbance (SED) as defined in ARM 37.86.3702. A child or adolescent must meet at least four of the following criteria for moderate or campus-based therapeutic group home services and five of the following criteria for intensive therapeutic group home services:

(a) Symptoms of the individual's emotional disturbance or mental illness are of a severe or persistent nature requiring more intensive treatment and clinical supervision than can be provided by outpatient mental health service.

(b) The beneficiary exhibits behaviors related to the covered diagnosis that result in significant risk for psychiatric hospitalization or placement in a more restrictive environment if therapeutic living care is not provided or the person is currently being treated or maintained in a more restrictive environment and requires a structured treatment environment in order to be successfully treated in a less restrictive setting.

(c) The prognosis for treatment of the individual's mental illness or emotional disturbance at a less restrictive level of care is very poor because the individual demonstrates three or more of the following due to the emotional disturbance or mental illness:

(i) significantly impaired interpersonal or social functioning;

(ii) significantly impaired educational or occupational functioning;

(iii) impairment of judgment; or

(iv) poor impulse control.

(d) As a result of the emotional disturbance or mental illness, the individual exhibits an inability to perform daily living activities in a developmentally appropriate manner.

(e) As a result of the emotional disturbance or mental illness, the beneficiary exhibits maladaptive or disruptive behavior that is developmentally inappropriate.

(3) The department hereby adopts and incorporates by reference the revised guidelines dated January 11, 2002 and providers of therapeutic youth group home services are required to abide by them. A copy of the revised guidelines may be obtained from the Department of Public Health and Human Services, Addictive and Mental Disorders Division, 555 Fuller , P.O. Box 202905, Helena, MT 59620-2905.

(4) For recipients determined medicaid eligible by the department as of the time of admission to the therapeutic youth group home, the certificate of need required under (2) must be:

(a) completed, signed and dated prior to, but no more than 30 days before, admission; and

(b) made by a team of health care professionals that has competence in diagnosis and treatment of mental illness, and that has knowledge of the recipient's situation, including the recipient's psychiatric condition. The team must include a physician that has competence in diagnosis and treatment of mental illness, preferably in child psychiatry, and must be a licensed mental health professional. The certificate of need must also be signed by an intensive case manager employed by a mental health center or other individual knowledgeable about local mental health services as designated by the department. No more than one member of the team of health care professionals may be professionally or financially associated with a therapeutic youth group home program.

(5) For recipients determined medicaid eligible by the department after admission to or discharge from the therapeutic youth group home, the certificate of need required under (2) is waived. A retrospective review to determine the medical necessity of the admission to the program and the treatment provided will be completed by the department or its designee at the request of the department, a provider, the individual or the individual's parent or guardian. Request for retrospective review must be:

(a) received within 14 days after the eligibility determination for recipients determined eligible following admission, but before discharge from the therapeutic youth group home; or

(b) received within 90 days after the eligibility determination for recipients determined eligible after discharge from the therapeutic youth group home.

(6) All certificates of need required under (2) must actually and personally be signed by each team member, except that signature stamps may be used if the team member actually and personally initials the document over the signature stamp. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 2001 MAR p. 27, Eff. 1/12/01; EMERG, AMD, 2002 MAR p. 1328, Eff. 4/26/02.)

Rule 20 reserved

37.86.2221 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT), THERAPEUTIC FAMILY CARE TREATMENT SERVICES (1) The therapeutic portion of medically necessary therapeutic family care treatment is covered for recipients with a primary diagnosis of severe emotional disturbance (SED) as defined in ARM 37.86.3702, or with both an emotional disturbance and a developmental disability, if the treatment is ordered by a licensed physician, licensed psychologist, masters level licensed clinical social worker (MSW) or a licensed professional counselor (LPC), and prior-authorized by the department or its designee according to the provisions of ARM 37.88.101.

(a) The therapeutic portion of moderate level therapeutic family care treatment, as defined in ARM Title 37, chapters 37 and 97, is covered if provided by a therapeutic family care agency licensed by and contracted with the department to provide moderate level therapeutic family care service.

(b) The therapeutic portion of permanency therapeutic family care treatment, as defined in (2)(c)(i), is covered if provided by a therapeutic family care agency licensed by and contracted with the department to provide intensive therapeutic family care services.

(i) Permanency therapeutic family care treatment is intensive level therapeutic family care treatment for which the foster family placement is permanent and which includes:

(A) individual, family and group therapies;

(B) clinical supervision provided by a licensed psychologist on a 1:20 ratio;

(C) a treatment manager who is a masters or bachelors level social worker with three years experience, on a 1:6 ratio;

(D) therapeutic aide services averaging at least 10 hours per week;

(E) respite care at least one weekend per month; and

(F) additional specialized training for families.

(c) Medicaid will not reimburse for room, board, maintenance or any other non-therapeutic component of therapeutic family care treatment.

(2) Medicaid reimbursement is not available for therapeutic youth family care services unless the provider submits to the department or its designee in accordance with these rules a complete and accurate certificate of need that certifies the necessary level of care. A child or adolescent must meet at least four of the following criteria for moderate therapeutic family care treatment services:

(a) Symptoms of the individual's emotional disturbance or mental illness are of a severe or persistent nature requiring more intensive treatment and clinical supervision than can be provided by outpatient mental health service.

(b) The beneficiary exhibits behaviors related to the covered diagnosis that result in significant risk that the beneficiary will require psychiatric hospitalization or placement in a more restrictive environment if therapeutic living care is not provided or the beneficiary is currently being treated or maintained in a more restrictive environment and requires a structured treatment environment in order to be successfully treated in a less restrictive setting.

(c) The prognosis for treatment of the individual's mental illness or emotional disturbance at a less restrictive level of care is very poor because the individual demonstrates three or more of the following due to the emotional disturbance or mental illness:

(i) significantly impaired interpersonal or social functioning;

(ii) significantly impaired educational or occupational functioning;

(iii) impairment of judgment; or

(iv) poor impulse control.

(d) As a result of the emotional disturbance or mental illness, the individual exhibits an inability to perform daily living activities in a developmentally appropriate manner.

(e) As a result of the emotional disturbance or mental illness, the beneficiary exhibits maladaptive or disruptive behavior that is developmentally inappropriate.

(3) Providers of therapeutic family care treatment services are required to abide by the revised guidelines adopted in ARM 37.86.2219.

(4) For recipients determined medicaid eligible by the department as of the time of admission to the therapeutic youth family care, the certificate of need required under (2) must be:

(a) completed, signed and dated prior to, but no more than 30 days before, admission; and

(b) made by a team of health care professionals that has competence in diagnosis and treatment of mental illness and that has knowledge of the recipient's situation, including the recipient's psychiatric condition. The team must include a physician that has competence in diagnosis and treatment of mental illness, preferably in child psychiatry, and must be a licensed mental health professional. The certificate of need must also be signed by an intensive case manager employed by a mental health center or other individual knowledgeable about local mental health services as designated by the department. No more than one member of the team of health care professionals may be professionally or financially associated with a therapeutic family care program.

(5) For recipients determined medicaid eligible by the department after admission to or discharge from the therapeutic youth family care, the certificate of need required under (2) is waived. A retrospective review to determine the medical necessity of the admission to the program and the treatment provided will be completed by the department or its designees at the request of the department, a provider, the individual or the individual's parent or guardian. Request for retrospective review must be:

(a) received within 14 days after the eligibility determination for recipients determined eligible following admission, but before discharge from therapeutic youth family care; or

(b) received 90 days after the eligibility determination for recipients determined eligible after discharge from therapeutic youth family care.

(6) All certificates of need required under (2) must actually and personally be signed by each team member, except that signature stamps may be used if the team member actually and personally initials the document over the signature stamp. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 2001 MAR p. 27, Eff. 1/12/01; EMERG, AMD, 2002 MAR p. 1328, Eff. 4/26/02; EMERG, AMD, 2003 MAR p. 1087, Eff. 5/23/03.)

Rules 22 and 23 reserved

37.86.2224 EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICE (EPSDT), COMPREHENSIVE SCHOOL AND COMMUNITY TREATMENT (1) Comprehensive school and community treatment (CSCT) means a comprehensive, planned course of outpatient treatment provided in the school and community to a child or adolescent with a serious emotional disturbance (SED), as defined in ARM 37.86.3702(2). A CSCT program may be operated by a licensed mental health center with a CSCT endorsement. The criteria for a mental health center's CSCT endorsement are found in ARM 37.106.1955.

(2) Comprehensive school and community treatment is not medically necessary when, in the determination of the department, the individual is receiving substantial mental health treatment outside the comprehensive school and community treatment program.

(3) Prior authorization pursuant to ARM 37.88.101 is required for outpatient therapy services that are provided to a child or adolescent concurrently with CSCT services. (History: 53-2-201 and 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; EMERG, NEW, 2003 MAR p. 1087, Eff. 5/23/03; AMD, 2005 MAR p. 1787, Eff. 9/23/05.)

37.86.2225 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT), CSCT PROGRAM BILLING

(1) Comprehensive school and community treatment (CSCT) services must be provided as set forth in ARM 37.106.1955, 37.106.1956, 37.106.1960, 37.106.1961 and 37.106.1965 in order to receive payment under this program.

(2) One full-time equivalent team may bill no more than 720 billing units per team per month. If a child or adolescent receives CSCT services during time periods when school is not regularly in session, then part-time staff may be used but the billing units must be reduced proportionately.

(a) A billing unit is 15 minutes.

(3) CSCT services provided by a licensed mental health center with an endorsement under ARM 37.106.1955 must be billed under the school district's provider number. Mental health services that are provided outside, or concurrently, with the CSCT program are billed under the mental health center's provider number with the appropriate CPT-4 procedure codes describing the services provided.

(4) As a medicaid provider of CSCT services, the school district is subject to all medicaid state and federal billing rules and regulations. A school district must:

(a) use a sliding fee schedule for children or adolescents not eligible for medicaid;

(b) bill all available financial resources for support of services including third party insurance and parent payments if applicable; and

(c) adequately document services to support the medicaid reimbursement received.

(5) There must be an appropriate level of direct contributions by the school district. Appropriate level means no less than is necessary to meet the nonfederal match requirements. (History: 53-2-201 and 53-6-113, MCA; IMP, 50-5-103, 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 2005 MAR p. 1786, Eff. 9/23/05.)

Rules 26 through 29 reserved

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37.86.2230 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT), SCHOOL BASED HEALTH RELATED SERVICES

(1) School based services for the purposes of medicaid are defined as medically necessary services provided through a public school district, joint board or cooperative. The public school district or cooperative must receive funds from the state general fund for the purpose of providing special education.

(2) School based health related services may include:

(a) physical therapy;

(b) speech-language pathology and audiology;

(c) occupational therapy;

(d) private duty nursing;

(e) personal care paraprofessional services;

(f) licensed psychologist services;

(g) school psychologist services;

(h) licensed clinical social worker services;

(i) licensed professional counselor services;

(j) comprehensive school and community treatment; and

(k) specialized transportation.

(3) School based health related services provided in the school to a child with disabilities, as that term is defined in Title 20, chapter 7, part 4, MCA, are eligible for medicaid reimbursement when those services are required by the child's individualized education program (IEP). The IEP is considered the order for health related services.

(4) School based health related services include services that are not required by an IEP but are provided by schools to students for a fee and billed under the student's name. Schools cannot bill medicaid for services not required by an IEP that are provided free to other children.

(5) All health related services billed to medicaid must have PASSPORT approval with the exception of mental health related services. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-111, MCA; NEW, 2003 MAR p. 1316, Eff. 6/27/03; AMD, 2004 MAR p. 83, Eff. 1/1/04.)

37.86.2231 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT), ELIGIBILITY AND SCOPE OF SCHOOL BASED HEALTH RELATED SERVICES (1) Only public school districts, full-service education cooperatives (established under 20-3-351, MCA) and joint boards are eligible for enrollment and participation in the school based Montana medicaid program.

(2) To qualify, the district, cooperative or joint board must receive special education funding from the state's general fund for the purpose of providing public education.

(3) School districts include only elementary, high school and K-12 districts organized to provide public educational services under the jurisdiction of a board of trustees as provided in Title 20, MCA.

(4) Full-service education cooperatives and joint boards include only those cooperatives and joint boards eligible to receive direct state aid payments from the superintendent of public instruction for the purpose of providing special education services consistent with the provisions of Title 20, MCA.

(5) Cooperatives, joint boards and non-public schools that do not receive state general funds for special education do not meet the criteria for medicaid enrollment and cannot participate in the medicaid program as a school-based provider. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-111, MCA; NEW, 2003 MAR p. 1316, Eff. 6/27/03.)

37.86.2232 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT), SCHOOL BASED PERSONAL CARE PARAPROFESSIONAL SERVICES (1) Personal care paraprofessional services are medically necessary in-school services provided to medicaid clients whose health conditions cause them to be functionally limited in performing activities of daily living.

(2) Personal care includes assistance with activities of daily living which include:

(a) grooming;

(b) transferring;

(c) mobility;

(d) eating;

(e) dressing;

(f) toileting; and

(g) bus escort for children with functional limitations.

(3) Personal care services do not include:

(a) any skilled services that require professional medical personnel; and

(b) instruction, tutoring or guidance in academics.

(4) Personal care service provided by an immediate family member will not be reimbursed. The term immediate family member includes:

(a) parent or stepparent;

(b) foster parent; or

(c) legal guardian. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-111, MCA; NEW, 2003 MAR p. 1316, Eff. 6/27/03.)

37.86.2233 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT), SCHOOL PSYCHOLOGIST SERVICES

(1) School psychologist services are those services provided by an individual with a class 6 specialist license with a school psychologist endorsement, as required by ARM 10.57.434.

(2) School psychologists may perform medically necessary evaluation and counseling services. Counseling services may be provided to individuals or groups.

(3) Group counseling and therapy services provided by a school psychologist must have no more than eight individuals participating in the group.

(4) When an eligible child receives school psychologist services and the psychologist consults with the parent as part of the child's treatment, time spent with the parent may be billed to medicaid under the child's name. The provider shall indicate on the claim that the child is the patient and state the child's diagnosis.

(5) Services considered educational are not a covered benefit under medicaid. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-111, MCA; NEW, 2003 MAR p. 1316, Eff. 6/27/03.)

37.86.2234 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT), SCHOOL BASED SPECIALIZED TRANSPORTATION SERVICES (1) Coverage of specialized transportation is limited to school based transportation of clients with disabilities for the purpose of obtaining nonemergency medical services covered by the medicaid program.

(a) The client must be in need of specialized transportation due to the client either being wheelchair-bound or subject to transport by stretcher.

(2) Coverage of specialized transportation is not available if another mode of transportation is appropriate for the transport of the client and is less costly.

(3) Specialized transportation services must be listed in the medicaid client's individualized education plan (IEP).

(4) Specialized transportation services may only be reimbursed by medicaid if the medicaid client receives a medicaid covered service listed in his or her IEP on the day transportation is provided. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-111, MCA; NEW, 2004 MAR p. 83, Eff. 1/1/04.)

Subchapter 23 reserved

Subchapter 24

Transportation Services

37.86.2401 TRANSPORTATION AND PER DIEM, DEFINITIONS

(1) "Per diem" means financial assistance with expenses for a medicaid recipient's meals and lodging enroute to and from, and while receiving medically necessary medical care.

(2) "Prior authorization" means the department or its designee's review and approval of the medical necessity and coverage of a service prior to delivery of the service.

(3) "Transportation service" means travel furnished by common carrier or private vehicle.

(a) Transportation service does not include ambulance services or specialized nonemergency medical transportation services for persons with disabilities. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-141, MCA; NEW, 1980 MAR p. 1190, Eff. 4/11/80; AMD, 1981 MAR p. 1976, Eff. 1/1/82; AMD, 1987 MAR p. 907, Eff. 7/1/87; AMD, 1995 MAR p. 1218, Eff. 7/1/95; TRANS, from SRS, 2000 MAR p. 481; AMD, 2001 MAR p. 1183, Eff. 7/6/01; AMD, 2003 MAR p. 1200, Eff. 6/13/03.)

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37.86.2402 TRANSPORTATION AND PER DIEM, REQUIREMENTS

(1) These requirements are in addition to those rule provisions generally applicable to medicaid providers.

(2) Coverage of transportation and per diem is limited to transportation and per diem necessary to obtain necessary medical services covered by the medicaid program.

(3) Coverage for transportation and per diem is only available for transportation and per diem to the site of medical services at the provider closest to the locality of the recipient.

(a) The closest provider is determined based on equivalent licensure or certification from the appropriate national or state licensing board without consideration of continuing education credits or units.

(b) The closest provider is determined using providers who are currently accepting medicaid recipients regardless of any individual client's:

(i) noncompliance with medical treatment plans;

(ii) financial or legal actions pending or filed against the provider; or

(iii) behavior (including but not limited to aggressive, inappropriate communication, failure to keep appointments or to arrive for appointments on time) that may have caused an individual not to be accepted as a patient in a particular practice.

(c) Transportation and per diem to a site, other than the one nearest to the locality of the recipient, is available if the combined total cost to the medicaid program of medical services and transportation and per diem at the more distant site is less than the total cost to the medicaid program for the provision of the services in the closest location.

(4) Coverage of transportation mileage fees does not include any other fees. Reimbursement is not available for other fees.

(5) Coverage of per diem does not include a round trip that can reasonably be made in one day.

(6) Coverage of transportation and per diem must be prior authorized by the department or its designee.

(a) If a medical appointment has been rescheduled, any prior authorization of the original appointment does not apply to the rescheduled appointment. Prior authorization must be obtained for the rescheduled appointment if the appointment is scheduled for a date other than the original appointment date.

(7) Reimbursement for transportation and per diem is made to the common carrier or lodging facility unless otherwise authorized by the department or its designee.

(8) Coverage of transportation is limited to the least expensive available means suitable to the recipient's medical needs.

(9) Coverage of transportation and per diem are not available for transportation and per diem costs incurred during a retroactive eligibility period.

(10) Coverage of transportation and per diem for an attendant is only available for an attendant that is determined to be medically necessary.

(a) Use of an attendant must be prior authorized by the department or its designee.

(b) Coverage of transportation and per diem for an attendant is limited to the same standards and fees as for a recipient.

(c) An attendant must return home after accompanying the recipient to the destination for provision of medical services unless the department or its designee determine that the cost of the attendant's stay for the recipient's course of treatment will be less than the cost of additional transportation costs resulting from the return to home.

(d) Coverage of per diem and transportation is available for a responsible adult to accompany a minor for whom the responsible adult is necessary to provide legal consent for medical procedures.

(11) If a recipient dies enroute to or during treatment outside of the recipient's community, the cost of the recipient's transportation to the medical service is reimbursable. The cost of returning the body of a deceased recipient is not reimbursable.

(12) Mileage reimbursement is rounded to the nearest whole mile.

(13) Mileage reimbursement is not available for local travel within the town or city where the client resides.

(14) Prior authorization is not a guarantee of payment as the department may subsequently deny payment based on factors other than medical necessity, including but not limited to ineligibility of the individual to whom services were provided or failure to comply with billing requirements set forth in ARM 37.85.406 or with any other medicaid rule or requirement.

(15) Commercial providers are required to maintain and retain original dispatch records for services provided to a Montana medicaid recipient that include:

(a) name of recipient;
(b) originating address;
(c) destination address;
(d) date;
(e) time;
(f) authorized units;
(g) charges; and
(h) the authorization number. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-141, MCA; NEW, 1980 MAR p. 1190, Eff. 4/11/80; AMD, 1980 MAR p. 1787, Eff. 6/27/80; AMD, 1981 MAR p. 1976, Eff. 1/1/82; AMD, 1985 MAR p. 250, Eff. 3/15/85; AMD, 1987 MAR p. 907, Eff. 7/1/87; AMD, 1995 MAR p. 1218, Eff. 7/1/95; TRANS, from SRS, 2000 MAR p. 481; AMD, 2001 MAR p. 1183, Eff. 7/6/01; AMD, 2003 MAR p. 1200, Eff. 6/13/03.)

Rules 03 and 04 reserved

37.86.2405 TRANSPORTATION AND PER DIEM, REIMBURSEMENT

(1) The department pays the lower of the following reimbursement rates for transportation services:

(a) the provider's actual submitted charge; or

(b) the department's fee schedule.

(2) The department hereby adopts and incorporates by reference the department's fee schedule dated July 2003 which sets forth the reimbursement rates for transportation, per diem and other medicaid services. A copy of the department's fee schedule may be obtained from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(3) No payment is available for personal vehicle mileage or per diem costs that total less than $5 in a calendar month.

(4) Reimbursement for transportation and per diem may not exceed the reimbursement as calculated and specified by the department in the prior authorization.

(5) Mileage for transportation in a personally owned vehicle is reimbursed at the rate of $.13 per mile. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-113 and 53-6-141, MCA; NEW, 1980 MAR p. 1190, Eff. 4/11/80; AMD, 1980 MAR p. 1787, Eff. 6/27/80; AMD, 1981 MAR p. 559, Eff. 6/12/81; AMD, 1981 MAR p. 1976, Eff. 1/1/82; AMD, 1982 MAR p. 1289, Eff. 7/1/82; AMD, 1987 MAR p. 161, Eff. 2/14/87; AMD, 1987 MAR p. 907, Eff. 7/1/87; AMD, 1995 MAR p. 1218, Eff. 7/1/95; AMD, 1998 MAR p. 2168, Eff. 8/14/98; AMD, 1999 MAR p. 1379, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 1664, Eff. 6/30/00; AMD, 2001 MAR p. 1183, Eff. 7/6/01; EMERG, AMD, 2002 MAR p. 2665, Eff. 9/27/02; AMD, 2003 MAR p. 999, Eff. 5/9/03; EMERG, AMD, 2003 MAR p. 1314, Eff. 7/1/03.)

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Subchapter 25

Specialized Nonemergency Medical Transportation

37.86.2501 SPECIALIZED NONEMERGENCY MEDICAL TRANSPORTATION, DEFINITIONS (1) Specialized nonemergency transportation means transportation service by a provider with a class B public service commission license allowing the provider to transport physically disabled individuals.

(2) "Wheelchair bound" means individuals cannot mobilize without a wheelchair and are not able to get into or out of the wheelchair without assistance.

(3) "Prior authorization" means the department or its designee's review and approval of the medical necessity and coverage of a service prior to delivery of the service. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-141, MCA; NEW, 1980 MAR p. 1190, Eff. 4/11/80; AMD, 1989 MAR p. 2254, Eff. 12/22/89; TRANS, from SRS, 2000 MAR p. 481; AMD, 2003 MAR p. 1200, Eff. 6/13/03.)

37.86.2502 SPECIALIZED NONEMERGENCY MEDICAL TRANSPORTATION, REQUIREMENTS (1) These requirements are in addition to those rule provisions generally applicable to medicaid providers.

(2) Coverage of specialized nonemergency medical transportation is limited to transportation of persons with disabilities for the purpose of obtaining nonemergency medical services covered by the medicaid program.

(a) The person must be in need of specialized transportation due to the person either being wheelchair-bound or subject to transport by stretcher.

(3) Coverage of specialized nonemergency medical transportation is not available if another mode of transportation is appropriate for the transport of the recipient and is less costly.

(4) Coverage of specialized nonemergency medical transportation is not available for costs for the service incurred during a retroactive eligibility period.

(5) Mileage reimbursement is rounded to the nearest whole mile.

(6) Coverage of specialized nonemergency medical transportation is limited to mileage fees and does not include any other fees. Reimbursement is not available for other fees.

(7) Specialized nonemergency medical transportation services must be prior authorized by the department or its designee.

(a) If a medical appointment has been rescheduled, any prior authorization of the original appointment does not apply to the rescheduled appointment. Prior authorization must be obtained for the rescheduled appointment if the appointment is scheduled for a date other than the original appointment date.

(8) Commercial providers are required to maintain and retain original dispatch records for services provided to a Montana medicaid recipient that include:

(a) name of recipient;
(b) originating address;
(c) destination address;
(d) date;
(e) time;
(f) authorized units;
(g) charges; and
(h) the authorization number. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-141, MCA; NEW, 1980 MAR p. 1190, Eff. 4/11/80; AMD, 1989 MAR p. 2254, Eff. 12/22/89; AMD, 1995 MAR p. 1218, Eff. 7/1/95; TRANS, from SRS, 2000 MAR p. 481; AMD, 2001 MAR p. 1183, Eff. 7/6/01; AMD, 2003 MAR p. 1200, Eff. 6/13/03.)

Rules 03 and 04 reserved

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37.86.2505 SPECIALIZED NONEMERGENCY MEDICAL TRANSPORTATION, REIMBURSEMENT (1) The department pays the lower of the following for specialized nonemergency medical transportation services:

(a) the provider's usual and customary charge; or

(b) the department's fee schedule.

(2) The department hereby adopts and incorporates by reference the department's fee schedule dated July 2003 which sets forth the reimbursement rates for specialized nonemergency medical transportation services and other medicaid services. A copy of the department's fee schedule may be obtained from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-113 and 53-6-141, MCA; NEW, 1980 MAR p. 1190, Eff. 4/11/80; AMD, 1981 MAR p. 559, Eff. 6/12/81; AMD, 1981 MAR p. 1975, Eff. 1/1/82; AMD, 1982 MAR p. 1289, Eff. 7/1/82; AMD, 1989 MAR p. 2254, Eff. 12/22/89; AMD, 1990 MAR p. 1479, Eff. 7/27/90; AMD, 1995 MAR p. 1218, Eff. 7/1/95; AMD, 1998 MAR p. 2168, Eff. 8/14/98; AMD, 1999 MAR p. 1379, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 1664, Eff. 6/30/00; AMD, 2001 MAR p. 1183, Eff. 7/6/01; EMERG, AMD, 2002 MAR p. 2665, Eff. 9/27/02; AMD, 2003 MAR p. 1200, Eff. 6/13/03; AMD, 2003 MAR p. 1314, Eff. 7/1/03.)

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Subchapter 26

Ambulance Services

37.86.2601 AMBULANCE SERVICES, DEFINITIONS (1) "Air ambulance services" means ambulance services provided by aircraft. There are two categories of air ambulance services, namely, fixed wing (airplane) and rotary wing (helicopter) aircraft.

(a) Fixed wing air ambulance services are furnished when the recipient's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing air ambulance may be necessary because the recipient's condition requires rapid transport to a treatment facility, and either great distances or other obstacles, for example, heavy traffic, preclude such rapid delivery. Transport by fixed wing air ambulance may also be necessary because the recipient is inaccessible by land or water ambulance vehicle.

(b) Rotary wing air ambulance services are furnished when the recipient's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by rotary wing air ambulance may be necessary because the recipient's condition requires rapid transport to a treatment facility, and either great distances or other obstacles, for example, heavy traffic, preclude such rapid delivery. Transport by rotary wing air ambulance may also be necessary because the recipient is inaccessible by land or water ambulance vehicle.

(2) "Ambulance" means a vehicle that:

(a) is specifically designed for transporting the sick or injured;

(b) contains a stretcher, linens, first aid supplies, oxygen equipment, and other lifesaving equipment required by state or local laws; and

(c) is staffed with personnel trained to provide first aid treatment.

(3) "Ambulance services" means services provided by a licensed ambulance provider in the ground or air transportation of a sick or injured person in a specially designed and equipped vehicle as defined above, which includes a trained ambulance attendant who is licensed or certified as required by state law.

(4) "Appropriate facility" means an institution equipped to provide the required hospital or nursing care for the illness or injury involved. In the case of a hospital, it also means that a physician or a physician specialist is available to provide the necessary care required to treat the patient's condition. However, the fact that the patient's personal physician does not have staff privileges in a hospital is not a consideration in determining whether the hospital is an appropriate facility.

(5) "Emergency services" means services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of such severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(6) "Ground ambulance services" means ambulance services provided by a vehicle designed to operate on the ground, including both water and land. Ground ambulance services include:

(a) Basic life support (BLS), which includes, when medically necessary, the provision of BLS services as defined in the national EMS education and practice blueprint for the EMT-basic, including other basic life support services, or the ambulance must be staffed by an individual who is qualified in accordance with state and local laws as an emergency medical technician-basic (EMT-basic);

(b) Basic life support emergency, which is furnished, when medically necessary, as specified above in (6)(a), in response to an emergency as defined in this rule;

(c) Advanced life support, level 1 (ALS1), which includes, when medically necessary, provision of an assessment by an ALS provider trained to the level of the emergency medical technician-intermediate or paramedic as defined in the national EMS education and practice blueprint or in accordance with state and local laws or the provision of one or more ALS interventions, that is, a procedure beyond the scope of an EMT-basic as defined in (6)(a). An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service.

(d) Advanced life support, level 1 (ALS1) emergency, which includes, when medically necessary, the provision of ALS1 services specified in (6)(c) above, in response to an emergency as defined in this rule;

(e) Advanced life support, level 2 (ALS2), which includes, when medically necessary, supplies and services including the administration of at least three separate administrations of one or more different medications or the provision of at least one of the following ALS procedures:

(i) manual defibrillation/cardioversion;

(ii) endotracheal intubation;

(iii) central venous line;

(iv) cardiac pacing;

(v) chest decompression;

(vi) surgical airway;

(vii) intraosseous line;

(f) Specialty care transport (SCT), which includes, when medically necessary, for a critically-injured or ill recipient, a level of interfacility service provided beyond the scope of the paramedic. SCT is necessary when a recipient's condition requires ongoing care that must be provided by one of more health professionals in an appropriate specialty area such as nursing, medicine, respiratory care, cardiovascular care or paramedic with additional training.

(7) "Nonemergency" means all scheduled transportation, regardless of origin and destination, that does not meet the above criteria for emergency. By definition, hospital discharge trips, trips to and from end stage renal disease (ESRD) facilities for maintenance dialysis, trips to and from other outpatient facilities for chemotherapy or radiation therapy, and other diagnostic and therapeutic services are scheduled runs and, therefore, are considered to be "nonemergency" services. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-113 and 53-6-141, MCA; NEW, 1980 MAR p. 1764, Eff. 6/27/80; AMD, 1993 MAR p. 2819, Eff. 1/1/94; TRANS, from SRS, 2000 MAR p. 481; AMD, 2001 MAR p. 1183, Eff. 7/6/01; AMD, 2003 MAR p. 1200, Eff. 6/13/03.)

NEXT PAGE IS 37-20403

37.86.2602 AMBULANCE SERVICES, REQUIREMENTS (1) These requirements are in addition to those rule provisions generally applicable to medicaid providers.

(2) Ambulance services must be provided by a licensed ambulance provider.

(3) Coverage of ambulance services is limited to transportation necessary to obtain medically necessary services from the nearest appropriate facility.

(4) Coverage for ambulance services is not available where transportation by a mode other than the ambulance could be utilized without endangering the patient's health, whether or not such other transportation is actually available.

(5) Ground ambulance service is covered when the patient's medical condition requires transportation by ambulance. The following are examples of circumstances which may be considered in determining the medical need for ground ambulance service. However, the presence or absence of any one or more of the following does not necessarily establish the medical need for the service:

(a) the patient is transported in an emergency situation, e.g., as a result of an accident or injury;

(b) the patient is unconscious or in shock;

(c) the patient requires oxygen as an emergency rather than a maintenance measure or requires other emergency treatment on the way to the destination;

(d) the patient has to remain immobile because of a fracture that has not been set or the possibility of a fracture;

(e) the patient sustains an acute stroke or myocardial infarction; or

(f) the patient is hemorrhaging.

(6) Air ambulance services are covered if:

(a) All coverage requirements for ground ambulance services as specified in this rule are met; and

(b) One of the following conditions is met:

(i) the point of pickup is inaccessible by land vehicle; or

(ii) great distances or other obstacles are involved, and getting the patient to the nearest hospital with appropriate facilities and emergency admission is essential, for example, a situation where land transportation is available, but the time required to transport the recipient by land rather than air would endanger the recipient's life or health.

(c) Air ambulance services may be covered for the transfer of a patient from one hospital to another if the transferring hospital does not have adequate facilities to provide the specialized medical services needed by the recipient and if the requirements of (6)(a) through (b)(ii) of this rule are met.

(i) Air ambulance services are not covered to transport a recipient from a hospital capable of treating the recipient to another hospital simply because the recipient or his family prefers a specific hospital or physician.

(ii) Mileage is paid only to the nearest appropriate facility.

(7) Nonemergency scheduled ambulance services must be prior authorized by the department or its designee.

(8) Medicaid benefits cease at the time of death. When a recipient is pronounced dead after an ambulance is called but before pickup, the ambulance service provided to the point of pickup is covered at the base rate. If a recipient is pronounced dead by a legally authorized individual before the ambulance is called, no payment will be made.

(9) Emergency ambulance services must be reported to the department's designee within 60 days of the emergency transport or within 90 days of the retroactive eligibility determination date.

(10) Ambulance claims for emergency services are screened for medical necessity and appropriateness by the designated review organization prior to payment.

(11) Mileage submitted for travel reimbursement purposes must be rounded to the nearest whole mile.

(12) Ambulance services are reimbursable only to the extent that such services are medically necessary based on the recipient's condition. Where ambulance services are reimbursable, payment will be based on the level of services provided rather than being based on the type of vehicle used, regardless of any state or local ordinances or any policies which contain requirements for ambulance staffing or furnishing of ambulance services. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-113 and 53-6-141, MCA; NEW, 1980 MAR p. 1764, Eff. 6/27/80; AMD, 1993 MAR p. 2819, Eff. 1/1/94; AMD, 1995 MAR p. 1218, Eff. 7/1/95; TRANS, from SRS, 2000 MAR p. 481; AMD, 2001 MAR p. 2247, Eff. 7/6/01; AMD, 2003 MAR p. 1200, Eff. 6/13/03.)

Rule 03 reserved

37.86.2604 AMBULANCE SERVICES, COVERAGE AND BILLABLE SERVICES (1) Except as provided in (2), the base charge specified in the department's fee schedule referred to in ARM 37.86.2605 for both basic life support (BLS) and advanced life support (ALS) ambulance services includes charges for all personnel, reusable supplies and capital equipment. This includes:

(a) The driver and attendants, including extra attendants;

(b) Nurse, physician, or nonambulance personnel in ambulance;

(c) All services provided by the personnel such as:

(i) CPR and defibrillation;

(ii) monitoring of pulse oximeter;

(iii) monitoring of vital signs;

(iv) EKG monitoring;

(v) IV and drug therapy;

(vi) intubation; and

(vii) glucometer check.

(d) ALS director;

(e) Reusable supplies, including but not limited to:

(i) ambu bag (bag valve mask);

(ii) anti-shock trousers (mast pants/suits);

(iii) cervical collar (neck immobilization item), nondisposable;

(iv) CPR board;

(v) CPR pocket mask, nondisposable; and

(vi) splints, nondisposable.

(f) Capital equipment, including but not limited to:

(i) heart monitor;

(ii) defibrillator;

(iii) aspirator (see suction);

(iv) back board;

(v) pulse oximeter;

(vi) IV pumps;

(vii) special stretchers such as:

(A) scoop stretcher;

(B) plastic stretcher;

(C) spine board; and

(D) flat cot;

(viii) suction and suction equipment;

(ix) glucometer;

(x) compressor; and

(xi) nebulizer.

(g) Billing charges;
(h) Decontamination of ambulance;
(i) Emergency charge;
(j) Night charge;
(k) Transporting of portable EKG to facility or location; and
(l) Waiting time.

(2) The following are not included in base rates for BLS and ALS and are separately billable:

(a) Mileage is allowed in addition to the base rate when the patient is transported to the nearest appropriate facility.

(i) charges for mileage must be based on loaded mileage only, i.e., from the pickup of a patient to their arrival destination; and

(ii) air ambulance mileage rate is calculated per actual loaded, patient onboard, miles flown and is expressed in statute miles, not nautical miles.

(b) EKG services (the technical component for obtaining tracing only, no interpretation and report) are reimbursable as a separate service for BLS, ALS and air ambulance. The reimbursement includes all EKG supplies.

(i) this service is allowed one time per transport;
(ii) reimbursement under this code includes the following:
(A) EKG paper;
(B) electrodes; and
(C) quick patch, fast patch, etc.

(c) Defibrillation disposable supplies are for supplies used when a patient is actually defibrillated. Reimbursement includes the following:

(i) lubricant/conduction gel;
(ii) wet saline gauze;
(iii) disposable electrodes;
(iv) all disposable supplies used with defibrillation; and
(v) quick patch, fast patch, etc.

(d) Routine disposable, nonreusable supplies may be covered and reimbursed separately from the ambulance base rate. A service is allowed as a one time charge per transport and includes the following supplies:

(i) bandages/dressings;
(ii) gauze/4x4s, etc.;
(iii) CPR pocket mask;
(iv) restraints;

(v) gloves;
(vi) linens (disposable);
(vii) tape;
(viii) emesis basin;
(ix) urinal;
(x) needles and syringes;
(xi) alcohol wipes;
(xii) hot/cold packs;
(xiii) elastic bandages;
(xiv) splints (disposables);
(xv) sterile water or saline for irrigation;
(xvi) chemstrips;
(xvii) disposable cervical collar;
(xviii) disposable ambu bag; and
(xix) disposable suction supplies (NC tube, tubing, canister, etc.).

(e) IV drug therapy disposable supplies may be reimbursed separately only if they are medically necessary as documented in the trip report. No payment will be made for IV supplies when they are provided merely on the basis of ambulance protocol.

(i) This service is allowed one time per transport.

(ii) Reimbursement for this service includes the following:

(A) all needles/catheters (angiocath, etc.);
(B) all IV tubing (micro, macro and specialized);
(C) tape;
(D) alcohol wipes;
(E) betadine or other antiseptic agents;
(F) filters;
(G) IV start kits;
(H) needles and syringes; and
(I) all dressings.

(f) Drugs may be reimbursed separately only if they are medically necessary as documented in the trip report.

(i) Injectable drugs and IV solutions administered in an emergency situation during the course of a covered ambulance trip are covered as nonreusable supplies. The medical necessity of such drugs and IV solutions and the need to administer them during transport must be clearly documented.

(g) Oxygen and oxygen supplies may be reimbursed separately only if they are medically necessary as documented in the trip report. No payment will be made for oxygen or oxygen supplies when they are provided merely on the basis of ambulance protocol.

(i) This service is allowed per 1/2 hour of oxygen usage per transport.

(ii) Reimbursement includes:

(A) oxygen;

(B) disposable oxygen supplies such as:

(I) cannulas;

(II) masks;

(III) tubing (extension, etc.);

(IV) humidifier;

(V) flow meter; and

(VI) nebulizers.

(iii) The administration of oxygen itself does not satisfy the requirement that a patient needs oxygen. If the patient travels for any other reason (e.g., church, grocery store, shopping, etc.) with portable oxygen, then they are not a candidate for ambulance transportation solely because of their oxygen requirement.

(h) Esophageal intubation may be reimbursed when establishing or maintaining an open airway but is not reimbursable for administering oxygen only.

(i) reimbursement for esophageal intubation includes the following:

(A) ET tube/NT tube;

(B) tape;

(C) gloves;

(D) bite mouthpiece;

(E) all airways (oral, esophageal, nasal, etc.);

(F) disposable ambu bag; and

(G) disposable airway suction equipment (suction catheters, tips, tubing and canister). (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 2001 MAR p. 1183, Eff. 7/6/01.)

37.86.2605 AMBULANCE SERVICES, REIMBURSEMENT (1) Except as provided in (4), the department pays the lowest of the following for ambulance services:

(a) the provider's usual and customary charge for the service; or

(b) the amount listed in the department's fee schedule.

(2) The department hereby adopts and incorporates by reference the department's fee schedule dated July 2003 which sets forth the reimbursement rates for ambulance services and other medicaid services. A copy of the department's fee schedule may be obtained from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(3) For items and services for which no fee has been set in the department's fee schedule referred to in (2), reimbursement will be based on the by-report method and rate specified in ARM 37.85.212.

(a) The department will review billings for items and services, other than those items for which a specific fee has been set, to determine the total number of times each such item has been billed by all providers in the aggregate within the state fiscal year period.

(b) Upon review of the aggregate billings as provided in (3)(a), the department will establish a fee for each item which has been billed in the following manner:

(i) if medicare sets a fee, the medicare fees are applicable as the medicaid fee; or

(ii) if medicare does not set a fee, the medicaid fees are set by evaluating the fees of similar services; or

(iii) a fee will be calculated based on the by-report percentage of the average charges billed by all providers in the aggregate for such items or services.

(4) The department may reimburse providers for ambulance services to transport patients to and from out-of-state facilities at negotiated fees where the department or its designee in its discretion determines that the in-state reimbursement rates are inadequate to assure that the recipient will receive medically necessary services.

(History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-113 and 53-6-141, MCA; NEW, 1980 MAR p. 1765, Eff. 6/27/80; AMD, 1981 MAR p. 559, Eff. 6/12/81; AMD, 1981 MAR p. 1975, Eff. 1/1/82; AMD, 1982 MAR p. 1289, Eff. 7/1/82; AMD, 1989 MAR p. 859, Eff. 6/30/89; AMD, 1990 MAR p. 1479, Eff. 7/27/90; AMD, 1991 MAR p. 1040, Eff. 7/1/91; AMD, 1993 MAR p. 2819, Eff. 11/1/93; AMD, 1995 MAR p. 1218, Eff. 7/1/95; AMD, 1998 MAR p. 2168, Eff. 8/14/98; AMD, 1999 MAR p. 1379, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 1664, Eff. 6/30/00; AMD, 2001 MAR p. 1119, Eff. 6/22/01; AMD, 2001 MAR p. 1183, Eff. 7/6/01; AMD, 2001 MAR p. 1476, Eff. 8/10/01; AMD, 2001 MAR p. 2156, Eff. 10/26/01; EMERG, AMD, 2002 MAR p. 2665, Eff. 9/27/02; AMD, 2003 MAR p. 1314, Eff. 7/1/03; AMD, 2003 MAR p. 1652, Eff. 8/1/03.)

37.86.2606 AMBULANCE SERVICES, QUALIFIED RATE ADJUSTMENT, PAYMENT ELIGIBILITY AND COMPUTATION (1) Eligible Montana ambulance providers may receive a qualified rate adjustment (QRA) from the department for ambulance services. Eligible providers are ambulance service providers that are either owned or operated by a local government unit.

(2) For an eligible provider to receive a QRA payment, the following conditions must be met:

(a) local government funds must be transferred in accordance with the contract required by (2)(d);

(b) the funds must be certified by the city or county treasurer, or an authorized local government official, as an intergovernmental transfer of public funds that qualifies as a payment of services eligible for federal financial participation (FFP, the federal government's share of a state's expenditures under the medicaid program) in accordance with 42 CFR 433.51 (2004);

(c) the provider must be in compliance with a signed, written contract with the department; and

(d) the written contract covering the requirements for the QRA payment must be executed prior to the issuance of the QRA payment. A retroactive effective date on the written agreement will not be allowed.

(3) To be eligible for FFP, the local government funds cannot be federal funds unless the federal funds are authorized by federal law to be used to match other federal funds.

(4) The QRA payment will be computed separately for all eligible ambulance providers using the following formula:

QRA payment = C x D x FMAP

(a) For the purposes of calculating the QRA payment amount, the following definitions apply:

(i) "C" represents the number of the provider's medicaid paid claims during the prior state fiscal year;

(ii) "D" represents the difference between the medicare and medicaid allowed amount per the healthcare common procedure coding system (HCPCS); and

(iii) "FMAP" represents the federal medical assistance percentage (FMAP) in effect during the prior state fiscal year. This percentage is the amount of federal participating matching funds for payment of Montana medicaid program services. The methodology for determining this percentage is set forth in 42 USC 1396b(a) (2004). The department adopts and incorporates by reference the methodology set out in 42 USC 1396b(a) (2004). A copy of that statute may be obtained from the Department of Public Health and Human Services, Health Resources Division, P.O. Box 202951, Helena, MT 59620-2951.

(5) The QRA is subject to the following conditions:

(a) the eligible ambulance provider's local government funds must be received by the department before it will disburse the QRA payment to the provider;

(b) information submitted from the eligible ambulance provider, the local medicare fiscal intermediary, and the Montana medicaid paid claims database will be used for calculations, utilizing data from the most recent state fiscal year with completed medicaid paid claims data;

(c) the limited situations where there is no medicare HCPCS code or fee schedule for the ambulance service, the billed charges from the provider will be used in the computation; and

(d) the ambulance provider is not allowed to bill medicaid more than it bills private payers and other insurers.

(6) The QRA payment is subject to the restrictions imposed by federal law and to the availability of sufficient local government, state and federal funding. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-113, MCA; NEW, 2005 MAR p. 385, Eff. 3/18/05.)

Subchapter 27 reserved